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American Institute of Certified Public Accountants. Subcommittee on Health Care Matters

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American Institute of Certified Public Accountants

INDUSTRY AUDIT GUIDE

HOSPITAL AUDIT GUIDE

PREPARED BY THE SUBCOMMITTEE ON HEALTH CARE MATTERS

Sixth Edition

Including

STATEMENTS OF POSITION

ISSUED BY THE ACCOUNTING AND AUDITING STANDARDS DIVISIONS

Note: This volume includes both the industry audit guide, *Hospital Audit Guide*, as it was originally published in 1973 and Statements of Position, *Clarification of Accounting, Auditing, and Reporting Practices Relating to Hospital Malpractice Loss Contingencies* (March 1, 1978), issued by the Auditing Standards Division, and *Accounting by Hospitals for Certain Marketable Equity Securities* (78-1), *Financial Accounting and Reporting by Hospitals Operated by a Governmental Unit* (78-7), *Reporting Practices Concerning Hospital-Related Organizations* (81-2), *Financial Reporting by Not-for-Profit Health Care Entities for Tax-Exempt Debt and Certain Funds Whose Use Is Limited* (85-1), and *Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues* (87-1), issued by the Accounting Standards Division. In using the guide, readers should refer to the additional material in the statements of position (see pages 59-141), which were not available when the guide was issued.

Patrick McNamee
Director, Audit and Accounting Guides

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NOTICE TO READERS

This audit guide is published for the guidance of members of the Institute in examining and reporting on financial statements of hospitals. It represents the considered opinion of the Committee on Health Care Institutions and as such contains the best thought of the profession as to the best practices in this area of reporting. Members should be aware that they may be called upon to justify departures from the Committee's recommendations.

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Hospital Audit Guide

Preface

This guide is issued to assist the independent auditor in auditing hospital financial statements that present financial position, changes in financial position, and results of operations. Although such statements are affected by the expanding role of third-party payors, the guide does not set forth reporting guidelines for third-party reimbursement purposes. References to third-party payors are made solely in connection with reporting on financial statements that present financial position, changes in financial position, and results of operations.

In writing this guide, it was recognized that information important to the public for interpretation of financial statements may differ from that required by management to carry on daily operations. Nothing herein precludes management from reporting information internally in any manner they consider necessary to fulfill this function.

Although the guide contains a glossary of terms used in the text, the reader may find the following publications of the American Hospital Association helpful in understanding terminology, accounting, and cost determinations:

Uniform Hospital Definitions (1960)
Chart of Accounts for Hospitals (revised 1966)
Cost Finding and Rate Setting for Hospitals (1968)
Internal Control and Internal Auditing for Hospitals (1969)

The Medicare Audit Guide, published by the American Institute of Certified Public Accountants in 1969, is also helpful in providing some background with respect to third-party reimbursement.

Committee on
Health Care Institutions

April 1972

Chapter 1

Introduction

Health care institutions include hospitals that provide short-term inpatient and outpatient care, as well as institutions that provide limited or long-term care, such as those for the mentally ill and infirm, for the physically handicapped, for child care, and for home care. Although some recommendations herein may be found applicable to other types of health care institutions, this guide applies only to hospitals.

Classification of Hospitals

Hospitals may be classified by type of control, such as:

Voluntary
- Community
- Religious Affiliated
- Educational Institution Affiliated
- Government Affiliated

Governmental
- Federal
- State
- County
- City

Proprietary (investor owned)

Accounting and Reporting Considerations

A large part of hospital services are for patients whose bills are paid in whole or in part by third-party payors, e.g., Medicare,

Medicaid, Blue Cross, and private insurance carriers. Reporting requirements of third-party payors usually influence record keeping. With the adoption of cost-based formulas for reimbursement by many third-party payors, requests for cost data supporting charges to patients have increased significantly. Data requested include statistics on occupancy, type of patients, nature of illnesses, average length of confinement by type of ailment, and—more important from an accounting standpoint—costs of providing service to particular groups of patients.

Besides third-parties' need for cost data, voluntary and government planning agencies will also need financial and statistical data to help them in improving delivery of health services. Further, as demand for service increases, financial support will also increase. This will more than likely require a higher level of accountability including more financial and statistical information. In this connection, the American Hospital Association states the following on page 24 of its *Statement on the Financial Requirements of Health Care Institutions and Services* (1969):

> Health care institutions have an obligation to disclose to the public evidence that all their funds are being effectively utilized in accordance with their stated purpose of operation. Such disclosure will be deemed to have been made if financial statements are made available on request to those with a legitimate interest in this information. These financial statements should be prepared in accordance with generally accepted accounting principles consistently applied, and should be accompanied by the stated opinion of an independent public accountant as to their fairness.

Chapter 2

Accounting and Reporting

Financial statements are designed to provide reliable and useful financial information about resources, obligations, and results of operation. This objective has been a guiding principle in the development of authoritative literature on generally accepted accounting principles, including this audit guide. In the preparation of this guide, consideration was given to those characteristics of hospitals that give rise to special accounting and reporting situations.

Application of Generally Accepted Accounting Principles

Since financial statements of hospitals present financial position, changes in financial position, and results of operations, and are increasingly being used by credit grantors, government agencies, and the community, the Committee on Health Care Institutions unanimously concludes that they should be prepared in accordance with generally accepted accounting principles. Accordingly, Accounting Principles Board Opinions and Accounting Research Bulletins that are presently in effect or issued after this guide is published should be applied in reporting on hospital financial statements unless they are inapplicable.

Messrs. Stipa and Winick assent to the publication of the guide, but dissent to the requirement that all investments be carried at cost.

Mr. Winick believes that hospitals should be permitted to carry marketable securities at fair market value as is permitted for other types of entities, so that the financial statements will better reflect the current financial position of the institution and management's performance with regard to such investments.

Mr. Stipa believes that the use of fair market value may in some cir-

cumstances more properly present financial position and operating results and that its use is more in keeping with the current philosophies of investment pooling, the recognition of unrealized gains and losses, and the total return concept now emphasized by institutional boards and their investment advisors. He therefore believes that the guide should permit the reporting of investments at either cost or fair market value, at least until the issuance of an authoritative accounting pronouncement regarding the carrying value of investments, and the related effect of unrealized gains and losses upon the financial statements.

Recommendations in the revised American Hospital Association's *Chart of Accounts for Hospitals* (1966) are generally compatible with generally accepted accounting principles and this guide. However, two recommendations in that publication presently are not in accordance with generally accepted accounting principles:

1. Carrying property, plant, and equipment at current replacement cost and basing depreciation on these values.
2. Carrying long-term security investments at current market value.[1]

Accounting for Property, Plant, and Equipment

Property, plant, and equipment and related liabilities should be accounted for as part of unrestricted funds, since segregation in a separate fund would imply the existence of restrictions on asset use. If limitations exist on the use of proceeds from a disposition of property, plant, and equipment, such limitations should be disclosed.

Depreciation should be recognized in hospital financial statements and is defined as follows:

> . . . a system of accounting which aims to distribute the cost or other basic value of tangible capital assets, less salvage (if any), over the estimated useful life of the unit (which may be a group of assets) in a systematic and rational manner. It is a process of allocation, not of valuation.[2]

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[1] The accounting profession is currently studying the subject of accounting for marketable securities.

[2] AICPA, Accounting Research Bulletin No. 43, "Restatement and Revision of Accounting Research Bulletins," Chapter 9, section c, paragraph 5 (1953).

If third parties reimburse hospitals for depreciation and restrict all or part of the reimbursement payment to replacements of, or additions to, property, plant, and equipment, such payment should be included in revenue in order to match this revenue and related depreciation expense. In the statement of changes in fund balances, the amount of the payment should be shown as a transfer from unrestricted to restricted funds and returned to unrestricted funds when expended.

Accumulation of funds for replacement or expansion of hospital facilities may result from a decision of the governing board to set aside resources for such purposes. When this is the case, these accumulations are considered to be designations of unrestricted fund balance and should be accounted for as appropriations of that balance. Provision for such designations of unrestricted fund balance should not be reflected as an expense in the statement of revenues and expenses.

Third-Party Reimbursement—Timing Differences

If a hospital uses accelerated depreciation for cost reimbursement purposes and a different method for financial statement purposes, the effect of such difference should be deferred. This will require deferring recognition of amounts received to the extent related to accelerated depreciation claimed for reimbursement but not reported in the financial statements; subsequently, the deferred revenue should be recognized in the years when the effect of the timing difference is reversed. If depreciation does not enter directly into reimbursement (as in negotiated contracts or in contracts with rates containing factors other than cost), timing differences may not arise; accordingly, it will not be necessary to use deferral accounting as recommended above.

In other instances where items are accounted for in different periods for reimbursement and financial reporting purposes (e.g., pension costs and vacation pay), the effect of the resulting timing differences should be shown in the financial statements.

Patient Service Revenues

Patient service revenues should be accounted for at established rates, regardless of whether the hospital expects to collect the

full amount. Such revenues should also be reported on an accrual basis in the period during which service is provided; other accounting methods, such as the "discharge method,"[3] are not acceptable.

Charity allowances, other arrangements for providing service at less than established rates, and the provision for uncollectible accounts should be reported either separately from gross revenues under "deductions from gross revenues" or by some other disclosure. Allowances of this type should also be accounted for on an accrual basis.

Prior Period Contractual Revenue Adjustments

There may be a difference each year between final settlement and amounts accrued at the end of a prior reporting period for retroactive cost reimbursement settlements. Since such accruals are generally susceptible of reasonable estimation, these differences usually should be included in the statement of revenues and expenses as an adjustment to appropriate allowance accounts. Differences should not be treated as prior period adjustments unless they meet the criteria set forth in paragraph 23 of Accounting Principles Board Opinion No. 9, "Reporting the Results of Operations," or are deemed to result from an error as indicated in APB Opinion No. 20, "Accounting Changes."

Donated Services, Supplies, Property, and Equipment

Many hospitals receive donated services of individuals. Fair value of donated services should be recorded when there is the equivalent of an employer-employee relationship and an objective basis for valuing such services. The value of services donated by organizations may be evidenced by a contractual relationship which may provide the basis for valuation.

Donated services are most likely to be recorded in a hospital operated by a religious group. If members of the religious group are not paid (or are paid less than the fair value of their serv-

[3] The "discharge method" recognizes revenue when the patient is discharged; no recognition is given to revenue accruing for services to patients not yet discharged.

ices), the lay-equivalent salaries (or the difference between lay-equivalent salaries and salaries paid) should be reported as expense with the credit to nonoperating revenue.

Donated medicines, linen, office supplies, and other materials which normally would be purchased by a hospital should be recorded at fair market value and reported as other operating revenue.

Donations of property and equipment should be recorded at fair market value at the date of contribution in the unrestricted fund balance, unless designated for endowment or other restricted purposes.

Unrestricted Gifts, Grants, and Bequests

Gifts, grants, and bequests that are not restricted by donors are subject to designation by the governing board and should be reported as nonoperating revenue; these items should not be credited directly to fund balances. Receipt of such unrestricted contributions may be an ordinary, normal, and recurring source of revenue on which some hospitals depend for continued operations. Since such revenue is available for the same uses as patient revenues, consistent presentation requires the reporting of these resources in the statement of revenues and expenses.

Frequently, unrestricted contributions are used in support of free care, education, research, and other expenses. In order to match expenses with the related revenues, these contributions should be included in the statement of revenues and expenses.

While unrestricted contributions may be used for the purchase of property, plant, and equipment, it should be recognized that other revenues likewise may be used for such capital purposes. Further, it must be presumed that if the donor wished to restrict his contribution as an addition to the permanent capital of the hospital, such as a gift for replacement of property, plant, and equipment or an endowment, he would have done so when donating the funds. In the absence of such restriction, the governing board has no obligation to maintain such contributions as part of the permanent capital of the hospital. Any action of the governing board appropriating these contributions does not alter this treatment; rather, such action is a designation of the unrestricted fund balance.

Grants and subsidies from governmental or community agencies may be given for general support of the hospital. Ordinarily, these items should be shown as nonoperating revenue. However, where the grantor specifies that this revenue is to be used for indigent care, it should be accounted for as a specific purpose gift (see Restricted Resources, below) and offset against allowances and uncollectible accounts when used.

When restrictions on term endowment funds expire, the released endowment should be reflected as nonoperating revenue in the statement of revenues and expenses.

Board-Designated Funds

Unrestricted resources may be appropriated or designated by the governing board for special uses. These resources may originate from unrestricted gifts or previously accumulated income. If the governing board appropriates resources in this manner, it should be recognized that the board nevertheless has the authority to rescind its action. For this reason such appropriations should be accounted for as part of unrestricted funds. Disclosure of board designations should be made in the financial statements.

Board-designated funds should be reported separately from donor-restricted funds. The term "restricted" should not be used in connection with board or other internal hospital appropriations or designations of funds.

Unrestricted Funds

All unrestricted resources in the balance sheet should be shown under the "unrestricted" caption (as illustrated in Exhibit A, pages 40 to 41) or otherwise disclosed, so the reader will not be misled as to resources available at the discretion of the governing board. A total of all unrestricted fund balances should be set forth.

Restricted Resources

Many hospitals receive, from donors and other third-parties, gifts, bequests, and grants that are restricted as to use. These

generally fall into three categories: (1) funds for specific operating purposes, (2) funds for additions to property, plant, and equipment, and (3) endowment funds.

Funds for specific operating purposes consist of donor-restricted resources and should be accounted for in a restricted fund or as deferred revenue in the unrestricted fund. These resources should be reported as "other operating" revenue in the financial statements of the period in which expenditures are made for the purpose intended by the donor.

Resources restricted by donors for additions to property, plant, and equipment are considered as contributions to the permanent capital of the hospital. Accordingly, these resources should be included in the restricted fund balance. A transfer of resources from restricted fund balance to unrestricted fund balance should be shown in the financial statements for the period in which expenditures are made for the purpose intended by the donor.

Endowment resources include both pure endowment funds (the principal of which may not be expended by the governing board) and term endowment funds (the principal of which may be expended upon release of the prohibition on expenditure of principal). Upon receipt, both types of endowment funds should be accounted for as restricted funds.

With respect to term endowment funds, footnote disclosure should be made of pertinent information such as the term of the endowment and the purposes for which the funds may be used during the term. When term endowment funds become available to the governing board for unrestricted purposes, they should be reported as "nonoperating revenue"; if these funds are restricted, they should be shown as a transfer to specific purpose or other restricted funds and accounted for as restricted funds.

Each restricted resource should be accounted for in accordance with instructions of the party placing restrictions on the resources. Restrictions on many resources are such that the funds can be grouped for reporting purposes even though they may require separate accounting in the records. Generally, restricted resources should be grouped for reporting purposes in the three categories discussed above.

Other examples of restricted resources include student loan, annuity, and life income funds.

Investment Income and Gains (Losses)

The statement of revenue and expenses should include income from investment of board-designated and other unrestricted funds; unrestricted income from endowment funds; and realized gains (or losses) on sale of investments of board-designated funds or other unrestricted funds. Unrealized gains or losses should not result in adjustment of financial statements, except for declines in value that result from an other than temporary impairment.

Realized gains (or losses) on sale of investments of endowment funds should be added to (or deducted from) endowment fund principal unless such items are legally available for other use or chargeable against other funds. Investment income of these funds should be accounted for in accordance with donors' instructions, i.e., as resources for specific operating purposes if restricted, or nonoperating revenue if not.

Income and net realized gains on investments of restricted funds, other than endowment funds, should be added to the respective fund balance unless legally available for unrestricted purposes. If available for unrestricted purposes, these items should be included in nonoperating revenue; if legal restrictions exist to the contrary, investment losses in excess of gains of these other restricted funds should be charged to restricted fund balance.

Gains or losses on investment trading between unrestricted and restricted funds should be recognized and separately disclosed in the financial statements. Gains or losses resulting from transactions between designated portions of the unrestricted fund should not be recognized.

Pledges

All pledges, less a provision for amounts uncollectible, should be accounted for in financial statements. Pledges should be appropriately classified in financial statements as unrestricted or restricted. If unrestricted, revenue from pledges (net of provision for uncollectibles) should be shown in financial statements of the period in which the pledge is made as nonoperating revenue. If part of the pledge is to be applied during some future period, that part should be reported in financial statements of the period in which it is received as deferred revenue or as additions to

restricted funds. If pledges are restricted in any other way they should be reported as restricted funds.

Funds Held in Trust by Others

Some hospitals have endowment-type funds held in trust by outside parties. The principal of the funds is usually not directly or indirectly controlled by the hospital. These funds should not be included in the balance sheet of the hospital but their existence should be disclosed.

In those instances where the trustee is to make distributions to the hospital, the hospital should report these distributions on an accrual basis as endowment income; also, disclosure of the right to future income may be appropriate in footnote form, depending upon the circumstances. If the distribution the trustee makes to the hospital is discretionary, the hospital should report these distributions as gifts or in any manner specified by the terms of the trust or directions of the trustee.

Hospitals as a Part of Other Organizations

A hospital may be a part of a larger organization, such as a medical school or a university, or one of a group of hospitals in a corporation or a subsidiary corporation. A government hospital may be a part of some larger governmental unit. Affiliated hospitals may be operated under special management and affiliation arrangements.

Accounting practices and reports of the hospital entity alone should conform to those set forth in this guide.

Other Related Organizations

Auxiliaries, guilds, fund-raising groups, and other related organizations frequently assist hospitals. If such organizations are not under the control of the hospital (usually these organizations are independent and are characterized by their own charter, bylaws, tax-exempt status, and governing board), the financial reporting of these organizations should be separate from reports of the hospital. If significant resources or operations of a

hospital are handled by such organizations, full disclosure should be made of the related facts and circumstances. If such organizations are under control of (or common control with) hospitals and handle hospital resources, their financial statements should be combined with those of the hospital.

Reporting an Accounting Change

Adjustments resulting from a change in accounting method to comply with recommendations in this audit guide should be treated as adjustments of prior periods, and financial statements presented for the periods affected should be restated appropriately.

For guidelines in reporting upon the financial statements that have been restated, the independent auditor should refer to Statement on Auditing Procedure No. 33, "Auditing Standards and Procedures" (Chapter 8, paragraphs 23-27).

For any accounting changes subsequent to those required for conforming with this audit guide, the Committee reaffirms the applicability of APB Opinion No. 20 which defines various types of accounting changes and establishes guides for determining the manner of reporting each type.

Chapter 3

Auditing Procedures—General

The primary purpose of this chapter and subsequent chapters on auditing is to present auditing procedures specifically applicable to hospitals. Although not contained in this guide, certain procedures common to audits of other organizations may also be pertinent.

Scope of Engagement

In each engagement, it should be understood in advance whether the audit is intended to cover supplementary information. In this regard, the independent auditor should consider issuing or obtaining a letter setting forth the scope and terms of his engagement.

Many third-party payors require hospitals to submit supplementary cost reports to obtain reimbursement for services provided to patients covered under such payor's plans. Many such supplementary reports require an independent auditor's opinion. Other types of reports examined by independent auditors include overhead cost reports for research contracts; reports to regional or national health care organizations; reports for contributors; and reports for local, state, or federal authorities in connection with tax exemption matters. The independent auditor should review all supplementary report requirements and plan his examination to comply with related filing deadlines.

Preparation for the Audit

As with any other examination, the independent auditor may find it helpful to set up a permanent file, which may include copies of the certificate of incorporation, bylaws, and organiza-

tion charts. The following items are of particular significance in hospital audits:

1. Documents relating to restrictions on gifts and bequests.
2. Contracts and agreements affecting finance and accounting, such as agreements with doctors, technicians, third-party payors, and so forth.
3. Tax-exemption letters.

Special emphasis should be placed on contractual arrangements with third-party payors. In most hospitals, third-party reimbursement significantly affects financial position and results of operations. Therefore, it is important for the independent auditor to familiarize himself with third-party reimbursement arrangements before undertaking his examination.[4]

Statistics

It is important for the independent auditor to familiarize himself with the method (or methods) by which the hospital seeks reimbursement for services. Current practice emphasizes a reliance on cost-finding as a means of calculating reimbursements from third parties under various plans and arrangements (most Blue Cross plans and Medicare use variations of cost-finding in reimbursement formulas). It is therefore recommended that the auditor know the details of the type or types of cost-finding required to be used by his hospital client.[5]

Hospitals usually compile statistical information on utilization of services and facilities. Early in his engagement the independent auditor should ascertain the extent to which his examination must be expanded to cover statistical data.

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[4] See section entitled "Cost Allocation and Apportionment" in Chapter 3 of Medicare Audit Guide (AICPA, 1969).

[5] To provide a general background to cost-finding, the independent auditor may find the following booklets helpful: *Cost Finding for Hospitals* (American Hospital Association, 1957) and *Cost Finding and Rate Setting for Hospitals* (American Hospital Association, 1968).

Other Considerations

To familiarize himself with an engagement and to pinpoint trends in operations and financial position, the independent auditor should usually review various data relating to the preceding period. Such review should ordinarily include documents of the prior year such as financial statements previously reported upon; interim financial statements, workpapers (particularly follow-up notes and memoranda for future audits), audit programs, internal control questionnaires, and management letters and correspondence. In addition to the above review of prior year documents, the auditor should ordinarily:

1. Compare financial statements of the current period with those of the prior period and obtain a satisfactory explanation for unusual variances.
2. Review minutes of governing board meetings and those of appropriate committees.
3. Ascertain, to the extent practicable and reasonable, compliance with terms of financial agreements.
4. Be aware of the requirements in paragraph 6 of Chapter 2 of SAP No. 33 in regard to non-arm's-length transactions.
5. Review the status of unsettled cost reimbursement reports for prior periods filed with third-party payors, and determine the adjustments, if any, that may be required as a result of this review.
6. Determine the propriety of the allocation of expenses between the hospital and affiliated nursing homes, educational institutions, and research programs.
7. Review relationship of affiliated organizations to the hospital and determine the propriety of combining their financial statements with those of the hospital (see Chapter 2, Other Related Organizations).
8. Review subsequent events and transactions and inquire of appropriate officers as to changes in financial position.
9. Obtain a representation letter on financial information being reported on, such as financial position, results of operations, contingent liabilities, and so forth.

Management Letters

It is a common but not required practice for the independent auditor to submit a letter to management commenting on his findings and recommendations regarding internal control, accounting procedures, and other matters. This letter should be directed to appropriate officials, generally the chief administrative officer, the governing board, or the audit committee.

Chapter 4

Auditing Procedures—Assets

Cash

As in other organizations, a hospital may maintain one or more bank accounts for operating purposes. Procedures for recording receipts and disbursements will vary with the organization. However, if the hospital receives donor-restricted funds, the auditor should determine if it is required to maintain such funds separately from the cash of unrestricted funds. The independent auditor should also determine, by examining underlying documentation, other legal requirements relating to restricted cash.

In his evaluation of internal control, the auditor should determine the location of cash collection points in addition to the cashier's office, such as emergency rooms, outpatient facilities, and special service departments. He should also review arrangements or agreements whereby the hospital collects cash for others.

Investments

Some noteworthy features of accounting for hospital investments are: (1) accounting by specific fund, (2) differentiating between principal and income transactions, and (3) pooling of investments.

In order to obtain investment flexibility, hospitals frequently pool resources of various funds for investment purposes. Because net results of operating the pool do not usually show up as such in financial statements, it is important that the net profit be allocated equitably to, and reported in, statements of participating

funds. In order to accomplish an equitable allocation, investment pools should be operated on the market-value method. Under the market-value method, each participating fund is assigned a number of units based on the percentage it owns of the total pool.

Market value is used to determine the number of units to be allocated to new funds entering the pool, or to calculate equity of funds withdrawing from the pool. Net profit of pool operations should be allocated to participating funds based on the funds' equity or share of the pool.

Auditing procedures applicable to investments may include reading custody agreements, reviewing control and safeguarding procedures, confirming or examining securities, testing authorization and documentation supporting transactions, reviewing the basis of valuation, and reporting income.

Specific inquiries in determining audit scope for investments should ordinarily include:

1. Do provisions of deeds of gifts prohibit pooling investments?
2. Do provisions of deeds of gifts provide restrictions on the nature or type of investments which may be acquired?
3. Does the accounting for pooled funds provide an equitable distribution of income and gains (losses)?
4. Does accounting for investments provide for appropriate distinction between unrestricted and restricted resources?
5. Does the accounting for premiums, discounts, and stock dividends provide for an appropriate distinction between principal and income?
6. Are standard procedures in effect for recording investments received as gifts; are they adequate? Do they include sending acknowledgment letters to donors?
7. Does accounting for investments distinguish between marketable and nonmarketable securities?
8. Has there been an impairment (other than a temporary one) in the carrying value of investments?

Accounts Receivable

In hospitals, accounts receivable have one characteristic not normally found in other organizations; full rate charges incurred

by patients are usually settled for amounts less than full rate. This difference may be attributable to contractual arrangements with third-party payors or to courtesy, charity, or other policy discounts; these items are usually not recognized in the hospital records until after the patient has been discharged.

Accounts-receivable controls may be maintained under the following classifications:

Inpatients not discharged:
Blue Cross
Medicare
Medicaid
Compensation and liability cases
Other

Inpatients discharged:
Blue Cross
Medicare
Medicaid
Compensation and liability cases
Other

Outpatients:
Blue Cross
Medicare
Medicaid
Compensation and liability cases
Other

Other accounts receivable:
Government appropriations
Community Chest(s)/United Fund
Tuitions and fees
Pledges
Sundry

In practice, most hospitals set up accounts receivable from inpatients and outpatients based on full-rate charges. Subsequently these hospitals reclassify such receivables to other payor classifications without recognizing at that time deductions that may be made at time of final settlement. For example, charges originally set up in an inpatient account may be transferred to

the Blue Cross account without recognizing the difference between that amount and the amount Blue Cross may pay in the future to settle the account. In such a case, the difference will be recognized in the hospital's records at the time payment is received from Blue Cross. This situation requires that an allowance be set up in financial statements being reported upon to reflect amounts that are expected to be collected. Similarly, an allowance should be set up to recognize other anticipated deductions such as charity, courtesy allowances, and policy discounts which will be recognized in the hospital's records subsequent to the balance sheet date.

Contractual arrangements between hospitals and third-party payors often provide for tentative billing rates which are subject to adjustment retroactively as a result of subsequent cost determination or negotiation. Although the rate finally agreed upon may not be known by the auditor when he is ready to issue his report, a reasonable estimate can usually be made of the adjustment and should be reflected in the financial statements. When settlement is finally made, any difference between the estimate reported in the financial statements and the finally settled amount recorded should be accounted for as indicated in Chapter 2 under the section on prior period adjustments.

In evaluating internal control and in determining the resultant extent of auditing procedures to be applied, the auditor should review the hospital's procedures for determining amounts that are collectible for services. In this regard he should evaluate the hospital's method of determining: (1) the indigency status of patients on a timely basis, (2) the point at which accounts are to be turned over to collection agencies or its in-house collection department, and (3) the estimated provision of uncollectible accounts.

Auditing procedures applicable to accounts receivable should ordinarily include confirmation from discharged patients and from third-party payors who have been billed by the hospital. Attempting to obtain confirmation of receivables from patients who are not discharged usually will be impracticable because such patients usually do not know their indebtedness until they are discharged. In such cases, alternative procedures as specified in SAP No. 43, "Confirmation of Receivables and Observation of

Inventories," should be followed. The existence of third-party payor contractual arrangements requires that appropriate audit procedures be performed, including:

1. Confirmation with the third-party payor, if practicable.
2. Review to determine that adequate provision has been made for differences between contractual interim billing rates and full-rate charges.
3. Review of computations made to estimate the amount of retroactive adjustments provided for in the accounts.
4. Review of related contracts to determine whether required adjustments have been reflected in the accounts.
5. Review of cost reimbursement reports to determine that they were prepared based on the principles of reimbursement of the third-party payor.

From the viewpoint of disclosure in the balance sheet, it is generally acceptable to combine all receivables in one amount. Where third-party payor receivables are material, they may be shown separately by payors (or debtors).

Interfund receivables and payables should be reviewed to evaluate whether such items can be expected to be liquidated within a reasonable period of time. The propriety of material advances between restricted and unrestricted funds should also be determined.

Inventories

Hospital inventories usually are not material in relation to financial position; inventory usage, however, may significantly affect hospital operations. The inventory classifications most frequently recorded in the accounts include: medical and surgical supplies; drugs and medicines; linens, uniforms, and garments; food; housekeeping supplies; office supplies; maintenance supplies; and stationery and forms. Of these, medical and surgical supplies and drugs and medicines are often the major items.

Internal control and auditing procedures with respect to hospital inventories differ in some respects from those followed in

other organizations. Some differences are as follows:

1. Hospitals frequently employ independent organizations to inventory and price drugs, medicines, and medical supplies. This is done because the genuineness and quality of these items can usually be determined more readily and accurately by these organizations than by the hospital's staff. The auditor should participate in the inventory program by reviewing the independent organization's procedures, observing physical counts, and testing pricing to the extent considered necessary in the circumstances.
2. Hospitals sometimes receive free merchandise, drugs, food, and other items. The auditor should ascertain that control procedures for these items are in effect and that appropriate recognition has been given in the accounts.

For financial statement presentation, inventories may be grouped in one total or listed by major classification, e.g., medical and surgical supplies, drugs and medicines, and so forth. The basis of inventory valuation should be disclosed.

Property, Plant, and Equipment

A hospital may have access to the use of plant facilities under a variety of arrangements: it may own the facilities outright; it may rent the facilities from independent or related organizations; it may partially rent (and partially own) them; it may have use of facilities provided by a related institution, such as a religious order, or by unrelated institutions under "affiliation" programs; or the facilities may be provided by a governmental agency or unit or a government-related hospital district. The auditor should inquire into, and the financial statements should disclose, the nature of any relationship between the hospital entity and lessors, bailors, or other owners of hospital property. Accounting Principles Board Opinion No. 5, "Reporting of Leases in Financial Statements of Lessee," should be referred to in accounting for lease arrangements.

In the absence of adequate property records, historical cost-based appraisals are generally acceptable for financial presenta-

tion purposes. However, the independent auditor should satisfy himself as to their propriety.

In evaluating depreciation policy, the auditor may refer to the American Hospital Association's *Chart of Accounts for Hospitals* which sets forth plant asset classifications and estimated useful lives of depreciable assets. He should also be aware that the accelerated pace of technological improvements in the medical field makes obsolescence an important factor to be considered in evaluating depreciation policy. APB Opinion No. 12, "Omnibus Opinion—1967," should be referred to for information about depreciable assets that should be disclosed in the financial statements.

Property, plant, and equipment not used for hospital operations should be reported separately; examples are real estate received as a gift and real estate investments of endowment funds.

Chapter 5

Auditing Procedures – Liabilities, Deferred Revenue, and Fund Balances

Liabilities and Deferred Revenue

This group of accounts includes notes payable, accounts payable, long-term and interfund debt, deferred revenue, and accruals for salaries, interest, vacations, and taxes. Included also are liabilities to third-party payors for working capital advances and for over-reimbursement.

Internal control should include separation of the approving and paying functions, safeguards over purchasing and receiving (including returned purchases and rebates), and a record of open purchase orders and commitments.

In addition to auditing procedures usually performed in connection with liability and deferred revenue accounts, the auditor, depending on the facts in each case, should:

1. Determine that interfund accounts are in balance and that the transactions recorded therein are authorized by the governing board either by specific approval of each transaction or by blanket approval of each type of transaction.
2. Review Medicare, Medicaid, or other third-party payor advance payment balances.
3. Review contract commitments with doctors, specialists, technicians, related parties, and others who perform services by arrangement with the hospital.

4. Substantiate deferred fees for educational programs and review existing subsidy or grant agreements for educational purposes.
5. Consider claims against the hospital for negligence and malpractice for possible disclosure of contingent liabilities. Evidence of claims may usually be obtained from claims agents, insurance companies, and attorneys. Obtaining written representation of claims information should be considered by the auditor.
6. Consider the effect on financial statements caused by timing differences between the period in which items enter into the determination of reimbursement under third-party reimbursement arrangements and the period in which such items enter into the financial statements.
7. Review policies requiring deposits from certain classes of patients, such as maternity patients. From admitting and medical records, test application of these deposits; confirmation on a test basis should be considered.
8. Ascertain that pension liabilities and income tax are accounted for in accordance with APB Opinion No. 8, "Accounting for the Cost of Pension Plans," and APB Opinion No. 11, "Accounting for Income Taxes," respectively.

Fund Balances

Fund balances represent the net equity of funds. Unrestricted fund balance includes working capital, net resources invested in plant assets, board-designated funds, and other unrestricted resources. Restricted funds consist of:

1. Specific purpose resources placed with the hospital in a trustee-like arrangement.
2. Plant replacement and expansion resources contributed for additions to property, plant, and equipment. These balances include amounts that are required to be used for property additions, as specified in agreements with third-party payors,

and must be distinguished from board-designated unrestricted funds.

3. Endowment fund resources held for the production of income. Endowment funds terminating after a period of time or upon the happening of a certain event should ordinarily be disclosed separately from other permanent endowment funds.

Individual funds comprising a particular total should be of the same general type. Specific purpose funds, for example, may include donor-restricted gifts, endowment income, and research grants—all of which are designated for a specific purpose or project. Competent evidential matter should be examined to support the purported nature of the fund and its purpose.

When examining such evidence (that is, minutes, agreements, contracts, and other documents) together with any related restrictions, the independent auditor should determine whether:

1. The description of the fund balance indicates the nature of the resources accounted for in the fund.
2. All subsidiary funds in a particular control fund balance have the same general characteristics.
3. Restricted and unrestricted fund balances are adequately described and differentiated in the financial statements.

In instances where the description of the fund balances is not adequate or where the general characteristics of subsidiary funds in a particular control fund balance are dissimilar, the description or characteristics of a fund balance should be further described and clarified in the footnotes to the financial statements.

Changes in Fund Balances

A statement of changes in fund balances should include all changes in funds. In auditing this statement, the independent auditor should test to satisfy himself that:

1. Transfers from endowment or other restricted funds are in accordance with donors' instructions.

2. Transfers have been made from restricted to unrestricted funds for additions to property, plant, and equipment financed by restricted resources.
3. Receipt and acknowledgment procedures for all gifts exist and that restrictive covenants are being complied with. (Income and expenditures included in restricted funds should be reviewed to determine that such items are accounted for in accordance with the governing instrument.)
4. Earnings (losses) on investments of each restricted fund are properly accounted for. (If investments are pooled, the auditor should test to satisfy himself that earnings (losses) are accounted for in appropriate funds.)
5. Changes in restricted fund balance involving research grants are in accordance with grant agreements. (The auditor should review the budget, expenditures, term, billing procedures, allowable cost provisions, and any renegotiation requirements. He should also review the adequacy of reserves for disallowances of cost items and other adjustments.)

Additions to restricted fund balances may result from fund-raising campaigns. When a separate campaign office is established to oversee the campaign, and it functions as a physically separate operation from the hospital with its own plan of internal control, the independent auditor should review control features, such as the following, to determine the basis and the extent of the testing required:

1. Control over the issuance of solicitation material, particularly pledge cards.
2. Separation of duties between individuals handling pledge cards and those handling cash.
3. Control over official records of gifts. (This type of control should be established initially and maintained throughout the campaign.)
4. Separation of duties involving receiving, depositing, and checking of official records against bank deposits.
5. Establishment of control over mail receipts.

6. The use of an independent party for some of the critical functions such as:
   a. A bank or other fiscal agent as receiving agent for the campaign.
   b. An independent organization for circularizations with pledgors.

Chapter 6

Auditing Procedures—Revenues and Expenses

Patient Service Revenue

The patient service revenue account should show a complete summary of gross revenues earned at established rates on an accrual basis.

Patient service revenue is comprised of three major classifications:

1. *Revenue from daily patient services (routine services).* This includes revenue from room, board, and general nursing services. Daily patient services may be classified by sources as follows:

   Medical
   Surgical
   Pediatrics
   Intensive care
   Psychiatric
   Obstetric
   Newborn nurseries
   Premature nurseries
   Other

2. *Revenue from other nursing services.* This includes revenue from services of other units organized under the nursing division and may be classified as follows:

   Operating room
   Recovery room

Delivery and labor room
Central services and supply
Intravenous therapy
Emergency service
Other

3. *Revenue from other professional services* (*ancillary services*). These may be classified as follows:

Laboratories
Blood bank
Electrocardiology
Radiology
Pharmacy
Anesthesiology
Physical therapy
Other

Patient service revenue accounts are often subclassified by type of patient:

Inpatients
Acute
Long-term

Outpatients
Emergency (referred or clinical)
Day care
Home care

Financial status
Self-pay
Blue Cross
Insurance
Government (Medicare, Medicaid, etc.)
Charity

Accommodation
Private
Semi-private
Ward

While many systems of internal control applicable to revenue of other organizations are also applicable to hospitals, the fol-

lowing deserve special note: internal control over routine charges should be maintained through the daily census while internal control over other charges may be effected by use of prenumbered departmental tickets for each revenue source or a log numbering system (initiated at the time of the request for service or the time service is provided) or such other system which assures that services provided are charged to the patient. Regardless of whether the service will be paid for, control over charges for the service provided should be exercised.

The independent auditor should make sufficient tests of both gross revenue and deductions therefrom to satisfy himself that the hospital's system of internal control and accounting procedures are comprehensive enough to cover any unusual circumstances with patients' accounts. To provide this assurance, the auditor ordinarily should:

1. Ascertain that revenue is accrued as service is performed and that related contractual and free-care allowances are accounted for in accordance with hospital policy.
2. Test propriety of charges to patients' accounts with patients' medical records; also compare medical records to the patients' accounts.
3. On a test basis compare patient charges and the hospital's standard billing rates.
4. Compare revenues of the current period with those of the prior period and obtain an explanation for unusual variances.
5. Review statistical reports (of patient days and lab tests, for example) to determine reliability of statistics presented.
6. Perform overall tests of revenue based upon patient days and other statistics of service for each classification. (In some situations, statistical records of specific types of service can be reconciled with recorded revenue.)

Deductions From Revenue

Deductions from revenue include (1) allowances which represent differences between gross revenue charges and amounts received (or to be received) from patients or third-party payors

for services performed and (2) a provision for uncollectible accounts. Types of allowances are:

1. *Charity allowances*—the difference between gross revenue charges at established rates and amounts received (or to be received) from indigent patients, voluntary agencies, or governmental units on behalf of specific indigent patients.
2. *Courtesy allowance or policy discounts*—the difference between established rates and amounts recovered or to be recovered for services provided for doctors, clergymen, employees, and employees' dependents.
3. *Contractual adjustments*—the difference between billings at established rates and amounts received or to be received from third-party payors under contractual agreements.

Allowances should be recorded on an accrual basis in accordance with generally accepted accounting principles.

For financial statement purposes, allowances and uncollectible accounts should be reported net of related revenue; such revenue includes gifts, grants, or endowment income restricted for assistance to charity patients or charity operations—for example, a free clinic. If material, such revenue should be disclosed in the financial statements.

Auditing procedures for revenue deductions, including an evaluation of internal control, should closely parallel those applicable to revenue and should ordinarily be performed in conjunction with the examination of accounts receivable and revenues. With regard to internal control, the auditor should ascertain that authority to approve deductions is separate from the cash and billing functions. The auditor should review the hospital's procedures for determining retroactive revenue adjustments as a result of cost determination or negotiations.

Contracts with third-party payors should be reviewed by the auditor to determine bases of reimbursement. This review should include computation of estimated adjustments to revenue required under such contracts. Frequently these adjustments will have to be estimated since required cost reports may not be available until after the auditor completes his examination. In evaluating such adjustments, the auditor may either (1) prepare the

reimbursement computation on an estimated basis; (2) compare per diem interim rates established by third-party payors with estimated average allowable per diem cost experienced, and multiply the difference by the patient days served under the contract; or (3) use other techniques which may be appropriate in the circumstances.

Other Operating Revenue

Other operating revenue includes revenue from nonpatient care services to patients, and sales and activities to persons other than patients. Such revenue is normal to the day-to-day operation of a hospital but should be accounted for separately from patient revenue.

Other operating revenue normally includes:

1. *Revenue from educational programs.* Includes tuition for schools, such as schools for nursing, laboratory technology, and X-ray technology.
2. *Research and other specific purpose grants.* Revenue from grants, gifts, or subsidies specified by donor for research, educational or other programs.
3. *Miscellaneous.* Other items includable in the classification of "other operating revenue" are:
   a. Revenue from rental of space in hospitals, clinics, and schools of nursing, and also from employees and others.
   b. Accommodation sales of medical and pharmacy supplies to employees, doctors, and others.
   c. Revenue from fees charged for transcripts or reproduction of medical or billing records for attorneys, insurance companies, and others.
   d. Proceeds from sale of cafeteria meals and guest trays to employees, medical staff, and visitors.
   e. Recovery of charges for personal telephone calls.
   f. Proceeds from sale of metal scrap, dietary waste, used X-ray film, placentas, and so forth.
   g. Revenue from gift shops, snack bars, newsstands, parking lots, coin-vending machines, and other service facilities operated by the hospital.

Nonoperating Revenue

Nonoperating revenue includes revenue not directly related to patient care, related patient services, or the sales of related goods. It usually includes the following:

1. *Unrestricted gifts.* This includes all gifts, grants, and legacies upon which there are no donor-imposed restrictions. Grants for general operating purposes from foundations and similar groups are includable in this classification. For financial statement purposes, all unrestricted gifts, grants, and legacies should be reported initially in this classification regardless of the ultimate purpose to which they may be designated by the governing board (see Unrestricted Gifts in Chapter 2).
2. *Unrestricted income from endowment funds.* This includes income earned on investments of those endowment funds that have no restrictions on income.
3. *Miscellaneous.* If an item of a type normally included in miscellaneous revenue is material, it should be separately disclosed. Items frequently grouped under this caption are:
   a. Income and gains from investments of unrestricted funds—includes interest, dividends, rents, or other income on investments as well as net gains or losses resulting from investment transactions.
   b. Donated services—the value of services contributed to the hospital by volunteers (see Donated Services, Supplies, Property, and Equipment in Chapter 2).
   c. Gain on sale of hospital properties.
   d. Net rentals of facilities not used in the operation of the hospital.
   e. Term endowment funds upon termination of restrictions.

The following internal control suggestions relate to nonpatient revenue (classified as other operating revenue or nonoperating revenue):

1. Revenue from educational programs can generally be controlled internally through enrollment statistics, registration records, or class admission reports. These records should be reconciled with revenues periodically.

2. Specific research projects should be properly authorized and a determination made as to the specific purpose funds available to cover related costs. Amounts of specific purpose funds transferred to cover authorized research expenditures are includable under nonpatient revenue. Research expenditures should be properly controlled and related to budgets and authorizations.
3. Internal control over unrestricted gifts may be exercised through written gift receipt and acknowledgment procedures.

Among audit tests to be considered in connection with the review of nonpatient revenue are the following:

1. Review of data and documents underlying gifts, grants, and bequests, including correspondence, acknowledgment receipts and notifications, and minutes of governing board and committee meetings.
2. Tests of grants for research and receipts for other restricted purposes by reference to appropriate contracts and documents, including budgets of related projects, cost reports, and other supporting documentation. Audit procedures should include reviewing field audit reports prepared by representatives of grantors. When the hospital is administering large grants involving research centers or similar operations, separation of functions and methods of apportionment of applicable expenses should be reviewed.
3. Comparison of recorded revenue from educational activities with estimated revenue determined by independent computation; this computation can usually be made using fee schedules and statistical enrollment reports.

Expenses

The American Hospital Association's *Chart of Accounts for Hospitals* may be used as a guide for establishing expense classifications in hospitals. Suggested major classifications of expenses are:

Nursing services
Other professional services

General services
Fiscal services
Administrative services

These classifications are subdivided by organizational unit (responsibility center).

An object or natural classification is also provided indicating the nature of the expense, such as:

Salaries and wages
Employee benefits
Fees to individuals and organizations
Supplies
Purchased services
Other expense

The extent of classifications and subclassifications depends upon many factors such as size of the hospital, degree of management and accounting sophistication, and external requirements for cost reports or comparability with other hospitals.

Expenses incurred in soliciting funds for a fund-raising campaign should be disclosed separately in the financial statements. Showing these expenses as a deduction from related revenue is usually an acceptable manner of reporting.

Internal control over hospital expenses requires the same general procedures as are required in any other organization: separation of duties, competent personnel, adequate payroll procedures, control over procurement and stores, and so forth.

Payrolls generally represent a major portion of a hospital's operating costs; therefore, tests of payrolls would represent an important procedure in the audit.

In addition to performing the regular tests of transactions, the auditor should:

1. Review comparative operational statistics and the relationship of such statistics to changes in expenses.
2. Examine agreements between the hospital and hospital-based physicians and:
   a. Test calculations based on agreements.
   b. Obtain written representation from the administrator outlining terms of any verbal agreement and, where appropriate, confirm the details of agreements with physicians.

c. Review the basis upon which the hospital has segregated charges if it bills for hospital-based physicians.

3. Test the hospital's method of recording services (and supplies) furnished to employees, such as value of meals, housing, and laundry; test distribution of these items to various departments and the treatment thereof for Social Security, withholding tax, and insurance purposes.

4. Test procedures for recording charges for special nurses and the rebilling of such charges to hospital patients.

5. For hospitals which record values for contributed services, the following should ordinarily be considered:
   a. Test the compensation value assigned to services contributed by non-paid individuals based on time spent and job description by comparison with compensation paid to workers in similar positions.
   b. Determine that maintenance costs incurred on behalf of contributing personnel have been considered in arriving at salary equivalents.
   c. Examine time records supporting the salary-equivalents for voluntary services and test computations.

6. Review fund-raising costs of endowment or building fund campaigns to determine whether such expenses are properly chargeable thereto.

7. Review and analyze, where necessary, the following:

   Maintenance and repairs
   Operations of plant
   Professional fees (other than medical)
   Administration and general expense
   Laboratory supplies and expense
   X-ray supplies and expense
   Pharmacy supplies and expense
   Dietary supplies and expense
   Operating room supplies and expense
   Medical and surgical expense
   New or unusual expense accounts
   Miscellaneous expense

Chapter 7

Financial Statements

Basic financial statements of a voluntary hospital consist of the following:

Balance sheet
Statement of revenues and expenses
Statement of changes in fund balances
Statement of changes in financial position
Notes to financial statements

Statements of revenues and expenses and of changes in fund balances may be set forth separately as shown in the accompanying Exhibits B and C, pages 42 and 43. Alternatively, a combined statement of revenues and expenses and changes in unrestricted fund balance—which also should reflect the details of changes in the composition of unrestricted funds—may be presented as shown in the accompanying Exhibit D, pages 44 and 45. If the alternative combined statement is provided, a separate statement of changes in the restricted fund balances should also be included.

Basic statements may be accompanied by schedules which set forth supplementary information such as the following:

Patient service revenue
Operating expenses

Illustrations of these statements and schedules follow. Illustrative statements for investor-owned (proprietary) hospitals are not included since they should follow reporting requirements of other investor-owned businesses.

It should be noted that information about the accounting policies adopted and followed by the hospital should be disclosed in the financial statements. This disclosure is recommended by APB Opinion No. 22, "Disclosure of Accounting Policies." The text of the Opinion should be referred to for the content and format of disclosure.

EXHIBIT A

Sample Hospital
Balance Sheet
December 31, 19__
With Comparative Figures for 19__

Assets	*Current Year*	*Prior Year*	*Liabilities and Fund Balances*	*Current Year*	*Prior Year*
			Unrestricted Funds		
Current:			Current:		
Cash	$ 133,000	$ 33,000	Notes payable to banks	$ 227,000	$ 300,000
Receivables (Note 3)	1,382,000	1,269,000	Current installments of long-term debt (Note 5)	90,000	90,000
Less estimated uncollectibles and allowances	(160,000)	(105,000)	Accounts payable	450,000	463,000
	1,222,000	1,164,000	Accrued expenses	150,000	147,000
Due from restricted funds	215,000	—	*Advances from third-party payors*	300,000	200,000
Inventories (if material, state basis)	176,000	183,000	Deferred revenue	10,000	10,000
Prepaid expenses	68,000	73,000	Total current liabilities	1,227,000	1,210,000
Total current assets	1,814,000	1,453,000	Deferred revenue—third-party reimbursement (Note 4)	200,000	90,000
Other:			Long-term debt (Note 5):		
Cash (Note 2)	143,000	40,000	Housing bonds	500,000	520,000
Investments (Notes 1 and 2)	1,427,000	1,740,000	Mortgage note	1,200,000	1,270,000
Property, plant, and equipment (Notes 4 and 5)	11,028,000	10,375,000	Total long-term debt	1,700,000	1,790,000
Less accumulated depreciation	(3,885,000)	(3,600,000)	Fund balance*	7,400,000	6,918,000
Net property, plant, and equipment	7,143,000	6,775,000			
Total (Note 2)	$10,527,000	$10,008,000	Total	$10,527,000	$10,008,000

	Restricted Funds			
Specific purpose funds:			Specific purpose funds:	
Cash	$ 1,260	$ 1,000	Due to unrestricted funds	$ 215,000 $ —
Investments (Note 1)	200,000	70,000	Fund balances:	
Grants receivable	90,000	—	Research grants	15,000 30,000
			Other	61,260 41,000
				76,260 71,000
Total specific purpose funds	$ 291,260	$ 71,000	Total specific purpose funds	$ 291,260 $ 71,000
Plant replacement and expansion funds:			Plant replacement and expansion funds:	
Cash	$ 10,000	$ 450,000	Fund balances:	
Investments (Note 1)	800,000	290,000	Restricted by third-party payors	$ 380,000 $ 150,000
Pledges receivable, net of estimated uncollectible	20,000	360,000	Other	450,000 950,000
Total plant replacement and expansion funds	$ 830,000	$ 1,100,000	Total plant replacement and expansion funds	$ 830,000 $ 1,100,000
Endowment funds:			Endowment funds:	
Cash	$ 50,000	$ 33,000	Fund balances:	
Investments (Note 1)	6,100,000	3,942,000	Permanent endowment	$ 4,850,000 $ 2,675,000
			Term endowment	1,300,000 1,300,000
Total endowment funds	$ 6,150,000	$ 3,975,000	Total endowment funds	$ 6,150,000 $ 3,975,000

See accompanying Notes to Financial Statements.

• Composition of the fund balance may be shown here, on the Statement of Changes in Fund Balance (such as illustrated in Exhibit D), or in a footnote.

EXHIBIT B

Sample Hospital
Statement of Revenues and Expenses

Year Ended December 31, 19___
With Comparative Figures for 19___

	Current Year	*Prior Year*
Patient service revenue	$8,500,000	$8,000,000
Allowances and uncollectible accounts (after deduction of related gifts, grants, subsidies, and other income—$55,000 and $40,000) (Notes 3 and 4)	(1,777,000)	(1,700,000)
Net patient service revenue	6,723,000	6,300,000
Other operating revenue (including $100,000 and $80,000 from specific purpose funds)	184,000	173,000
Total operating revenue	6,907,000	6,473,000
Operating expenses:		
Nursing services	2,200,000	2,000,000
Other professional services	1,900,000	1,700,000
General services	2,100,000	2,000,000
Fiscal services	375,000	360,000
Administrative services (including interest expense of $50,000 and $40,000)	400,000	375,000
Provision for depreciation	300,000	250,000
Total operating expenses	7,275,000	6,685,000
Loss from operations	(368,000)	(212,000)
Nonoperating revenue:		
Unrestricted gifts and bequests	228,000	205,000
Unrestricted income from endowment funds	170,000	80,000
Income and gains from board-designated funds	54,000	41,000
Total nonoperating revenue	452,000	326,000
Excess of revenues over expenses	$ 84,000	$ 114,000

See accompanying Notes to Financial Statements.

Sample Hospital

EXHIBIT C

Statement of Changes in Fund Balances

Year Ended December 31, 19___
With Comparative Figures for 19___

	Current Year	*Prior Year*
Unrestricted Funds		
Balance at beginning of year	$6,918,000	$6,242,000
Excess of revenues over expenses	84,000	114,000
Transferred from plant replacement and expansion funds to finance property, plant, and equipment expenditures	628,000	762,000
Transferred to plant replacement and expansion funds to reflect third-party payor revenue restricted to property, plant, and equipment replacement	(230,000)	(200,000)
Balance at end of year	$7,400,000*	$6,918,000
Restricted Funds		
Specific purpose funds:		
Balance at beginning of year	$ 71,000	$ 50,000
Restricted gifts and bequests	35,000	20,000
Research grants	35,000	45,000
Income from investments	35,260	39,000
Gain on sale of investments	8,000	—
Transferred to:		
Other operating revenue	(100,000)	(80,000)
Allowances and uncollectible accounts	(8,000)	(3,000)
Balance at end of year	$ 76,260	$ 71,000
Plant replacement and expansion funds:		
Balance at beginning of year	$1,100,000	$1,494,000
Restricted gifts and bequests	113,000	150,000
Income from investments	15,000	18,000
Transferred to unrestricted funds (described above)	(628,000)	(762,000)
Transferred from unrestricted funds (described above)	230,000	200,000
Balance at end of year	$ 830,000	$1,100,000
Endowment funds:		
Balance at beginning of year	$3,975,000	$2,875,000
Restricted gifts and bequests	2,000,000	1,000,000
Net gain on sale of investments	175,000	100,000
Balance at end of year	$6,150,000	$3,975,000

See accompanying Notes to Financial Statements.

* Composition of the balance may be shown here, on the balance sheet, or in a footnote.

EXHIBIT D

Sample Hospital

Statement of Revenues and Expenses and Changes in Unrestricted Fund Balance (Alternative Presentation)

Year Ended December 31, 19___
With Comparative Figures for 19___

	Current Year				Prior Year
	Operations	*Other*	*Plant*	*Total*	*Total*
Patient service revenue	$8,500,000	—	—	$8,500,000	$8,000,000
Allowances and uncollectible accounts (after deduction of related gifts, grants, subsidies, and other income—$55,000 and $40,000) (Notes 3 and 4)	(1,777,000)	—	—	(1,777,000)	(1,700,000)
Net patient service revenue	6,723,000	—	—	6,723,000	6,300,000
Other operating revenue (including $100,000 and $80,000 from specific purpose funds)	184,000	—	—	184,000	173,000
Total operating revenue	6,907,000	—	—	6,907,000	6,473,000
Operating expenses:					
Nursing services	2,200,000			2,200,000	
Other professional services	1,900,000			1,900,000	
General services	2,100,000			2,100,000	
Fiscal services	375,000			375,000	

Administrative services (including interest expense of $50,000 and $40,000)	400,000			400,000	
Provision for depreciation	300,000			300,000	
Total operating expenses	7,275,000			7,275,000	
Loss from operations	(368,000)	—	—	(368,000)	(212,000)
Nonoperating revenue:					
Unrestricted gifts and bequests	—	$ 228,000	—	228,000	205,000
Unrestricted income from endowment funds	—	170,000	—	170,000	80,000
Income and gains from board-designated funds	—	24,000	$ 30,000	54,000	41,000
Excess of revenues over expenses	(368,000)	422,000	30,000	84,000	114,000
Fund balance at beginning of year	153,000	1,780,000	4,985,000	6,918,000	6,242,000
Transferred from restricted funds	—	—	628,000	628,000	762,000
Transferred to restricted funds	(230,000)	—	—	(230,000)	(200,000)
Intra-fund transfers	832,000	(632,000)	(200,000)	—0—	—0—
Fund balance at end of year	$ 387,000	$1,570,000	$5,443,000	$7,400,000	$6,918,000

See accompanying Notes to Financial Statements.

NOTE: If the alternative format above is presented, the total column must be included to present fairly the information contained therein.

EXHIBIT E

Sample Hospital
Statement of Changes in Financial Position of Unrestricted Fund

With Comparative Figures for 19___
Year Ended December 31, 19___

	Current Year	*Prior Year*
Funds provided:		
Loss from operations	$ (368,000)	$ (212,000)
Deduct (add) items included in operations not requiring (providing) funds:		
Provision for depreciation	300,000	250,000
Increase in deferred third-party reimbursement	110,000	90,000
Revenue restricted to property, plant, and equipment replacement transferred to plant replacement and expansion fund	(230,000)	(200,000)
Funds required for operations	(188,000)	(72,000)
Nonoperating revenue	452,000	326,000
Funds derived from operations and nonoperating revenues	264,000	254,000
Decrease in board-designated funds	210,000	—
Property, plant, and equipment expenditures financed by plant replacement and expansion funds	628,000	762,000
Decrease in working capital	—	46,000
	$1,102,000	$1,062,000

	Current Year	*Prior Year*
Funds applied:		
Additions to property, plant, and equipment	$ 668,000	$ 762,000
Reduction of long-term debt	90,000	90,000
Increase in board-designated funds	—	210,000
Increase in working capital	344,000	—
	$1,102,000	$1,062,000
Changes in working capital:		
Increase (decrease) in current assets:		
Cash	$ 100,000	$ (50,000)
Receivables	58,000	75,000
Due from restricted funds	215,000	(100,000)
Inventories	(7,000)	16,000
Prepaid expenses	(5,000)	1,000
	361,000	(58,000)
Increase(decrease) in current liabilities:		
Note payable to banks	(73,000)	50,000
Accounts payable	(13,000)	10,000
Accrued expenses	3,000	2,000
Advances from third-party payors	100,000	40,000
Deferred revenue	—	2,000
	17,000	104,000
Increase (decrease) in working capital	$ 344,000	$ (46,000)

See accompanying Notes to Financial Statements.

Sample Hospital

Notes to Financial Statements

December 31, 19___

NOTE 1: Investments are stated in the financial statements at cost. Cost and quoted market values at December 31, ——— are summarized as follows:

	Cost	*Quoted Market*
Board-designated funds	$1,427,000	$1,430,000
Specific-purpose funds	200,000	210,000
Plant replacement and expansion funds	800,000	838,000
Endowment funds	6,100,000	8,200,000

NOTE 2: Of total unrestricted assets of $10,527,000, $1,570,000 has been designated for expansion of outpatient facilities; these assets are shown as other assets because they are not expected to be expended during 19_____.

NOTE 3: Revenues received under cost reimbursement agreements totaling $4,000,000 for the current year and $3,000,000 for the prior year are subject to audit and retroactive adjustment by third-party payors. Provisions for estimated retroactive adjustments under these agreements have been provided.

NOTE 4: Property, plant, and equipment is stated at cost. A summary of the accounts and the related accumulated depreciation follows:

	Cost	*Accumulated Depreciation*
Land	$ 300,000	$ —0—
Land improvements	140,000	100,000
Buildings	7,088,000	2,885,000
Fixed equipment	2,000,000	800,000
Movable equipment	1,500,000	100,000
	$11,028,000	$3,885,000

Depreciation is determined on a straight-line basis for financial statement purposes. The hospital uses accelerated depreciation to determine reimbursable costs under certain third-party reimbursement agreements.

Cost reimbursement revenue in the amount of $110,000 resulting from the difference in depreciation methods is deferred in the current year and will be taken into income in future years.

NOTE 5: The 3 percent housing bonds are payable in varying annual amounts to 19___ and are collateralized by a mortgage on a nurses' residence carried at $800,000.

The mortgage note is payable in quarterly installments of $17,500 with interest at 4 percent through 19___, and is collateralized by land and buildings carried at $2,800,000.

NOTE 6: The hospital has a noncontributory pension plan covering substantially all employees. Total pension expense for the year was $48,000, which includes amortization of prior service cost over a period of 20 years. The hospital's policy is to fund pension costs accrued. The actuarially computed value of vested benefits as of December 31, 19___ exceeds net assets of the pension fund and balance sheet accruals by approximately $156,000.

Schedule 1

Sample Hospital

Patient Service Revenues

Year Ended December 31, 19__
With Comparative Figures for 19__

	Current Year	*Prior Year*
Daily patient services:	$	
Medical and surgical		
Pediatrics		
Intensive care		
Psychiatric		
Obstetric		
Newborn nurseries		
Premature nurseries		
Other		
Other nursing services:		
Operating rooms		
Recovery rooms		
Delivery and labor rooms		
Central services and supply		
Intravenous therapy		
Emergency units		
Other		
Other professional services:		
Laboratories		
Blood bank		
Electrocardiology		
Electroencephalography		
Radiology		
Pharmacy		
Anesthesiology		
Physical therapy		
Social service		
Other		
Total patient service revenue	$	

Sample Hospital

Schedule 2

Operating Expenses

Year Ended December 31, 19__
With Comparative Figures for 19__

	Current Year		*Prior Year*	
	Personal Services	*Supplies and Other Expense*	*Personal Services*	*Supplies and Other Expense*
Nursing services:	$			
Administrative office				
Medical and surgical				
Pediatrics				
Intensive care				
Psychiatric				
Obstetric				
Newborn nurseries				
Premature nurseries				
Other units				
Operating rooms				
Recovery rooms				
Delivery and labor rooms				
Central services and supply				
Intravenous therapy				
Emergency service				
Education				
Other				
	$			
Other professional services:	$			
Administrative office				
Laboratories				
Blood bank				
Electrocardiology				
Electroencephalography				
Radiology				
Clinics				
Inhalation therapy				
Medical records				
Pharmacy				
Anesthesiology				
Physical therapy				
Social service				
Education				
Research				
Other				
	$			

Sample Hospital
Operating Expenses (cont'd)

Schedule 2 (cont'd)

	Current Year		Prior Year	
	Personal Services	Supplies and Other Expense	Personal Services	Supplies and Other Expense
General services:	$			
Administrative office				
Dietary				
Plant engineering				
Power plant				
Electricity and refrigeration				
Maintenance shops				
Automotive service				
Elevator operators				
Security				
Housekeeping				
Laundry and linen				
Personnel quarters				
Printing and duplicating				
Physicians' offices				
Auxiliary units				
	$			
Fiscal services:	$			
Administrative office				
Accounting				
Admitting				
Credits and collections				
Data processing				
Receiving				
Cashier				
Communications				
Storerooms				
Other				
	$			
Administrative services:	$			
Executive office				
Personnel				
Purchasing				
Public relations				
Governing board				
Medical staff				
Employee benefits				
Insurance				
Auxiliaries				
Interest				
Other				
	$			

Chapter 8

Independent Auditors' Reports

Statement on Auditing Procedure No. 33, which prescribes the recommended form of auditor's report, should be referred to in reporting on hospital financial statements. As provided in Chapter 10 of this Statement, such a report may contain an unqualified opinion, a qualified opinion, a disclaimer of opinion, or an adverse opinion. The facts and circumstances in each examination will govern the appropriate opinion. Reports appearing in this chapter are presented to illustrate the application of the form of auditors' reports prescribed in Chapter 10 of SAP No. 33 in some situations commonly faced by the independent auditor in examining financial statements of hospitals.

When supplemental schedules accompany the basic exhibits, the auditor should either indicate in the opinion paragraph the responsibility he is taking for the schedules, or include a separate opinion on the schedules. (See Chapter 12 of SAP No. 33.)

Departures From Standard Short-Form Report

If the valuation of investments is not in accordance with generally accepted accounting principles, a qualification of the report might be stated as follows:

> It is the practice of the hospital to reflect investments of endowment funds at quoted market value at the balance sheet date whereas under generally accepted accounting principles, such assets should be reported at cost. Such valuations at December 31, 19___ and December 31, 19___ were $XX and $XX, respectively, in excess of cost.

In our opinion, except for the effect of reflecting investments of endowment funds at market value as stated in the preceding paragraph ....

Under Medicare and other third-party payor programs, the hospital and the third party may agree to a rate schedule for interim charges with the understanding that a retroactive adjustment may be made based upon allowable costs as contractually defined. Such adjustments are usually based on periodic cost reports prepared by the hospital subject to audit by third parties.

The independent auditor may be able to satisfy himself as to the amounts due to or from payors for the current as well as prior years. In other cases, cost reports may not have been filed; cost reports that were filed may be insufficient for the independent auditor's purposes because of the absence of adequate supporting data; or the review of cost reports may indicate that the amount of final settlement is significantly uncertain because of the possible effect of a matter(s) not reasonably determinable at the time of his report, as in the case of disputes over the interpretation of Medicare regulations.

If, as a result of his review of underlying data, the independent auditor believes that amounts shown as due from (or due to) the third party have not been properly determined; or if there has been a "scope limitation" on his examination, he should issue an "except for" opinion, an adverse opinion, or a disclaimer of opinion as appropriate in the circumstances. However, if he believes that the amount has been fairly determined based on the best information available at the time of his examination but the amount of final settlement is uncertain because of the possible effect of a matter(s) not reasonably determinable at that time, a "subject to" opinion or a disclaimer of opinion may be appropriate. Examples of forms of such opinions are:

Absence of Data Supporting Settlement

Medicare accounts receivable at June 30, 19__ and the related revenues included in the accompanying financial statements are based upon billings at provisional rates. Final reimbursement under the Medicare program is based on allowable costs which must be reported to and reviewed by the Medicare fiscal intermediary. Sufficient data was not available to evaluate the effect, if any, which the final determination of reimbursable costs may

have upon accounts receivable, patient revenue, loss for the year, and unrestricted fund balance.

In our opinion, except for the effect, if any, of the final determination of the Medicare reimbursement referred to in the preceding paragraph . . . .

Uncertainty of Amount of Settlement

During 19___, the fiscal intermediary questioned the hospital's entitlement to reimbursement of services rendered to Medicare patients on the basis that such services may have been custodial in nature and not medically necessary. Since resolution of this question cannot be ascertained until final audit and negotiation between the hospital and the Medicare intermediary and is based on medical matters beyond substantiation by auditing procedures, it is uncertain whether the amounts reported as revenue and receivables arising from services rendered under the Medicare program will be reimbursed.

In our opinion, subject to the effect, if any, of the final determination of Medicare reimbursement as described in the preceding paragraph . . . .

APPENDIX A

Glossary

Knowledge of special terminology used in hospital accounting is necessary for an understanding of a hospital's financial statements. Terms most frequently used are defined in this section. No attempt has been made to define all accounting, technical, medical, and semi-medical terms used.

Definitions used in this section have been adapted from a variety of sources, including:

Terminology bulletins of the AICPA

Kohler's *A Dictionary for Accountants* (Prentice-Hall, Inc., 1970)

Chart of Accounts for Hospitals (American Hospital Association, 1966)

Uniform Hospital Definitions (American Hospital Association, 1960)

College and University Business Administration (American Council on Education, 1968)

Allowance. The difference between gross revenue from services rendered and amounts received (or to be received) from patients or third-party payors. Allowances are to be distinguished from uncollectible accounts resulting from credit losses.

Annuity funds. Funds given to an institution as consideration for an agreement to pay periodically to the donor (or specified designated individuals) stipulated amounts, for the period set forth in the agreement.

Board-designated funds. Unrestricted funds set aside by the governing board for specific purposes or projects.

Board-designated investment funds. Unrestricted funds which, at the discretion of the governing board, have been designated for investment to produce income as if they were endowment funds.

Construction and equipment funds. *See* Plant replacement and expansion funds.

Contractual replacement funds. Funds set aside by agreement with third-party payors for renewal and replacement of property, plant, and equipment.

Contributed services. *See* Donated services.

Cost finding. The segregation of direct costs by cost centers, the allocation of overhead costs to revenue-producing and other centers between inpatients, outpatients, and other classifications.

Donated services. The estimated monetary value of service of personnel who receive no monetary compensation or partial compensation for their services. The term is usually applied to services rendered by members of religious orders, societies, or similar groups to institutions operated by or affiliated with such institutions.

Endowment funds. Funds in which a *donor* has stipulated, as a condition of his gift, that the principal of the fund is to be maintained inviolate and in perpetuity and that only income from investments of the fund may be expended. (*See also* Term-endowment funds.)

Functional classification. The grouping of expenses according to the operating purposes (e.g., patient care, education, research) for which costs are incurred.

Fund. A self-contained accounting entity set up to account for specific activity or project.

Fund balance. The excess of assets over liabilities (net equity). An excess of liabilities over assets is known as a *deficit* in fund balance.

Funds functioning as endowment. *See* Board-designated investment fund, which is the preferred term.

Funds held in trust by others. Funds held and administered, at the direction of the donor, by an outside trustee for the benefit of an institution or institutions.

Governing board. The policy-making body of the institution. Some of the responsibilities usually attributed to the governing board may be assumed by appropriate committees.

Living trust funds. Funds acquired by an institution subject to agreement whereby resources are made available to the institution on condition that the institution pay periodically to a designated person, or persons, the income earned on the resources acquired for the lifetime of the designated person, or persons, or for a specified period.

Non-expendable funds. *See* Endowment funds, which is the preferred term.

Object classification. A method of classifying expenditures according to their natural classification such as salaries and wages, employee benefits, supplies, purchased services, etc.

Permanent funds. *See* Endowment funds, which is the preferred term.

Plant. Physical properties used for institutional purposes; i.e., land, building, improvements, equipment, and so forth. The term does not include real estate or properties of restricted or unrestricted funds not used for hospital operations.

Plant replacement and expansion funds. Funds donated for renewal or replacement of plant.

Pooled investments. Assets of two or more funds consolidated for investment purposes.

Restricted funds. Funds restricted by donors for specific purposes. The term refers to specific purpose and endowment funds.

Retirement of indebtedness funds. Funds required by external sources to be used to meet debt service charges and the retirement of indebtedness on plant assets. The term "sinking funds" is sometimes used to describe these funds.

Share of pooled investments. The proportion of pooled investments, including accumulated gains or losses, owned by a particular fund, usually expressed by a number (units) indicating the fractional ownership of total shares in the pool or by a percentage expressing the portion of the total pool owned by the particular fund.

Sinking fund. *See* Retirement of indebtedness funds.

Special purpose fund. *See* Specific purpose funds.

Specific purpose funds. Funds restricted for a specific purpose or project. Board-designated funds do not constitute specific purpose funds.

Temporary funds. *See* Specific purpose funds.

Term endowment funds. Donated funds which by the terms of the agreement become available either for any legitimate purpose designated by the board or for a specific purpose designated by the donor upon the happening of an event or upon the passage of a stated period of time.

Unexpended plant funds. *See* Plant replacement and expansion funds.

Unrestricted funds. Funds which bear no external restrictions as to use or purpose; i.e., funds which can be used for any legitimate purpose designated by the governing board as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion, and for endowment.

APPENDIX B

Statement of Position

CLARIFICATION OF ACCOUNTING, AUDITING, AND REPORTING PRACTICES RELATING TO HOSPITAL MALPRACTICE LOSS CONTINGENCIES

March 1, 1978

Issued by the Auditing Standards Division
American Institute of Certified Public Accountants

NOTICE TO READERS

The American Institute of Certified Public Accountants has issued a series of industry-oriented audit guides that present recommendations on auditing procedures and auditors' reports and, in some instances, on accounting principles, and a series of accounting guides that present recommendations on accounting principles. Based on experience in the application of these guides, AICPA subcommittees or task forces may from time to time conclude that it is desirable to change a guide. A statement of position is used to revise or clarify certain of the recommendations in the guide to which it relates. A statement of position represents the considered judgment of the responsible AICPA subcommittee or task force.

To the extent that a statement of position is concerned with auditing procedures and auditors' reports, its degree of authority is the same as that of the audit guide to which it relates. As to such matters, members should be aware that they may be called upon to justify departures from the recommendations of the subcommittee or task force.

To the extent that a statement of position relates to standards of financial accounting or reporting (accounting principles), the recommendations of the subcommittee or task force are subject to ultimate disposition by the Financial Accounting Standards Board. The recommendations are made for the purpose of urging the FASB to promulgate standards that the subcommittee or task force believes would be in the public interest.

Subcommittee on Health Care Matters

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The subcommittee gratefully acknowledges the contributions made to the development of this Statement of Position by former members of the subcommittee Robert A. Cerrone, William Freitag, Robert A. Jordan, Robert F. Rosenstiel, and Allen J. Winick, and by former AICPA staff aide to the subcommittee, Edward J. Mazur.

Table of Contents

Hospital Audit Guide

Introduction

In 1972, the AICPA issued the industry audit guide, *Hospital Audit Guide*. Chapter 5 of that guide includes suggested auditing procedures relating to claims against a hospital for negligence and malpractice, including possible disclosure of contingent liabilities. The size of current malpractice claim settlements, the substantial increase in malpractice insurance rates, the increasing practice of hospitals to reduce or terminate malpractice liability coverage, and other factors are conditions that differ significantly from those prevailing at the time the guide was issued. The AICPA Subcommittee on Health Care Matters believes that item five on page 25 of the guide should be superseded and replaced by this statement of position.

Background

Over the years, hospital malpractice risks were generally covered by insurance on an occurrence basis[1] at reasonable costs. Insurers found the business desirable and actively competed for it. Medicare, Medicaid, and other third-party payors have long recognized the premiums for such insurance as allowable costs of conducting the operations of a hospital.

The major changes that have taken place in hospital malpractice insurance have resulted from the changing social climate in the United States. Increased emphasis on consumerism and greater public awareness of the possibility of bringing suit, among other factors, have created an entirely new environment for malpractice claims. In this environment, professionals and institutions are being treated somewhat as guarantors of the success of their efforts. Juries in court cases are disposed to awarding large amounts of money, and suits brought by individuals on reaching their majority for occurrences during their infancy have added to the prob-

[1] A policy that insures for incidents that occur during the period of coverage is on an "occurrence" basis.

lems in this area. As a result, malpractice costs have increased significantly.

Insurers reacted in varying ways—by reducing or attempting to reduce the limits of their liability (for example, switching from occurrence to claims-made policies,[2] lowering limits on policies, and offering policies with very large deductibles), by raising premiums, and by refusing to renew policies and withdrawing from this aspect of the insurance business.

Hospitals, too, reacted in a variety of ways to control the cost of malpractice insurance. Some assumed or increased deductibles in basic policies, thus becoming partially uninsured. Others chose to cancel all malpractice coverage, thus becoming totally uninsured. Hospital groups throughout the country formed captive insurance companies; however, due to insufficient experience the premiums are retrospective in many cases.

Some insurance commissioners have tried to force insurers to continue to insure malpractice risks, but many major insurers have withdrawn. Several state legislatures have passed laws limiting the liability of the providers and requiring an arbitration-like procedure relating to malpractice cases. However, at least one such law has been declared unconstitutional.

It appears that one of the reasons for the withdrawal of insurers from this business is the difficulty of estimating potential losses. This may tend to diminish as improved estimation techniques are developed and as claims settled under present conditions become part of the body of experience. The effect of inflation represents an additional variable which complicates the process of estimating losses.

Auditing Procedures

Auditors should give particular attention to whether loss contingencies resulting from malpractice risks have been accrued for and disclosed in accordance with the requirements of FASB Statement No. 5, *Accounting for Contingencies,* and FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss.*

In evaluating the reasonableness of the accrual for estimated losses from malpractice claims, the auditor should include in his

[2] A policy that insures for claims made during the period of coverage is on a "claims-made" basis.

consideration the amount of insurance coverage, the insurance adjuster's evaluation of known claims, the financial reputation of the insurer, the type of coverage (claims-made or occurrence), the amount of the deductible provisions, the possibility of retrospective adjustments, and related legal and other costs.

With respect to litigation, claims, and assessments, paragraph 4 of Statement on Auditing Standards No. 12, *Inquiry of a Client's Lawyer Concerning Litigation, Claims, and Assessments,* states that the independent auditor should obtain evidential matter relevant to the following factors:

- The existence of a condition, situation, or set of circumstances indicating an uncertainty as to the possible loss to an entity arising from litigation, claims, and assessments.
- The period in which the underlying cause for legal action occurred.
- The degree of probability of an unfavorable outcome.
- The amount or range of potential loss.

In addition, the auditor should apply the procedures outlined in paragraphs 5 and 6 of SAS No. 12, which are summarized below:

- Inquire of and discuss with management the policies and procedures adopted for identifying, evaluating, and accounting for litigation, claims, and assessments.
- Obtain from management a description and evaluation of litigation, claims, and assessments.
- Examine documents in the client's possession concerning litigation, claims, and assessments.
- Obtain assurance from management that it has disclosed all unasserted claims that the lawyer has advised are probable of assertion and must be disclosed in accordance with FASB Statement No. 5.
- Request the client's management to send a letter of inquiry to those lawyers with whom management consulted concerning litigation, claims, and assessments.

The independent auditor's examination normally includes certain other procedures undertaken for different purposes that might also disclose litigation, claims, and assessments, such as reading

minutes of meetings, contracts, agreements, and correspondence, and inspecting other pertinent documents (SAS No. 12, paragraph 7). Attention should also be given to internal controls and procedures related to identifying malpractice incidents.

A letter of audit inquiry to the lawyer handling the claims is the auditor's primary means of obtaining corroboration of the information furnished by management concerning claims made and known incidents for which claims have not been made that are either uninsured or in excess of insurance coverage. SAS No. 12 should be followed to solicit legal counsel's evaluation of the likelihood of an unfavorable outcome of litigation, claims, and assessments and his estimate, if one can be made, of the amount or range of potential loss.

As to unasserted claims, paragraph 30 of FASB Statement No. 5, *Accounting for Contingencies,* indicates there should be a provision for

> uninsured losses resulting from injury to others or damage to the property of others that took place prior to the date of the financial statements, even though the enterprise may not become aware of those matters until after that date, if the experience of the enterprise or other information enables it to make a reasonable estimate of the loss that was incurred prior to the date of its financial statements.

It would be appropriate for the auditor to consider prior estimates and prior loss experience, analyses of the frequency of past claims, and other actuarial considerations in evaluating the reasonableness of management's estimate of the loss (if any) that was incurred with respect to unasserted claims before the date of the financial statements. Although the experience of an individual hospital may not be statistically significant, the experience of larger units of similar character or of aggregates of similar institutions may be a useful guide.

When the hospital's malpractice risks are insured on a claims-made basis, the auditor should obtain a written representation from management, if applicable, that it intends to renew the hospital's malpractice insurance coverage on a claims-made basis and that it has no reason to believe that the hospital may be prevented from renewing such coverage.

The cancellation (or termination) of claims-made malpractice insurance coverage will generally cause the hospital to be at risk

for all unreported incidents that occurred during the term of the cancelled policy unless, at cancellation, coverage was obtained for such incidents. Such cancellation may give rise, therefore, to a liability for unreported incidents that occurred prior to cancellation. Since terms for notifying the carrier of malpractice incidents vary, the policy should be reviewed for specific requirements.

Accounting and Disclosure

The estimated loss contingency resulting from malpractice risks should be accrued for and disclosed in conformity with the provisions of FASB Statement No. 5 and FASB Interpretation No. 14. A loss contingency should be accrued for if an incident of malpractice has occurred that results in a probable loss that can be reasonably estimated. Current circumstances may make it difficult to estimate the amount of the loss. A qualified actuary may be helpful both in deriving estimates of losses incurred but not reported and in quantifying the uncertainties inherent in such estimates.[3]

If the hospital has exposure to material malpractice contingencies in excess of amounts accruable under FASB Statement No. 5 and FASB Interpretation No. 14, such contingencies should be disclosed in accordance with paragraphs 9 through 11 of FASB Statement No. 5.

Because of the significance of malpractice risks and the related costs, disclosure of a hospital's policy with regard to malpractice insurance coverage and changes in that policy may be necessary for presentation of the financial statements in conformity with generally accepted accounting principles. If premiums are determined retrospectively, disclosure of that fact may be necessary. Particular attention should be paid to paragraphs 44 and 45 of FASB Statement No. 5 if a hospital or group of hospitals insures malpractice risks through a captive or joint insurance company or if a hospital's malpractice insurance premiums are determined retrospectively.

FASB Statement No. 5 requires disclosure of unasserted claims only if it is probable that a claim will be asserted and there is a reasonable possibility that the outcome will be unfavorable.

[3] In such circumstances, the independent auditor should be guided by the provisions of SAS No. 11, *Using the Work of a Specialist.*

Because of the significance of malpractice risks to hospitals, the Subcommittee on Health Care Matters recommends that hospitals also disclose in their financial statements the possibility of losses from unasserted claims that do not meet those criteria.

An example of appropriate financial statement disclosure of uncertainties arising from possible malpractice follows.

> Malpractice claims in excess of insurance coverage have been asserted against the hospital by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. Counsel is unable to conclude about the ultimate outcome of the actions. There are known incidents occurring through (balance sheet date) that may result in the assertion of additional claims, and other claims may be asserted arising from services provided to patients in the past. The hospital is unable to estimate the ultimate cost, if any, of the settlement of such potential claims and, accordingly, no accrual has been made for them.

If the hospital has changed its malpractice insurance coverage from an occurrence basis policy to a claims-made policy, it may be appropriate to disclose the related facts and circumstances in the financial statements. The following is an example of such disclosure.

> Effective January 1, 19XX, the hospital changed its malpractice insurance coverage from an occurrence basis policy to a claims-made policy. Claims based on occurrences prior to January 1, 19XX, are insured under the old policy. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term but reported subsequently will be uninsured.

In the first year a hospital is uninsured for its malpractice risks to any material degree, whether by use of deductibles or otherwise, the related facts and circumstances should be described in the financial statements. Such disclosure should include the effect on comparability of insurance expense in the year of change. The following is an example of such disclosure.

> The hospital has terminated its malpractice coverage as of the beginning of the current year. In the prior year, malpractice insurance premiums in the amount of $_____ were charged to

income. During the current year, no charges for premiums or for actual or potential claims have been made.

Information may become available after the balance sheet date, but before the issuance of the auditor's report, indicating that it was probable that a malpractice loss had been incurred as of the balance sheet date. When the amount of the loss can be reasonably estimated, it should be accrued by a charge to income (see paragraph 8 of FASB Statement No. 5). An example would be the filing of a claim after the balance sheet date which relates to services rendered prior to that date. Information may become available after the balance sheet date, but before the issuance of the auditor's report, which may require disclosure so that the financial statements will not be misleading (see paragraph 11 of FASB Statement No. 5). An example of a subsequent event that may require disclosure is the termination of a hospital's malpractice insurance coverage.

Malpractice loss amounts eligible for reimbursement by third-party payors may be materially different from amounts accruable under FASB Statement No. 5. Recognition should be given to the effect of timing differences that may result.[4] In addition, any restrictions on funds required to be set aside should be disclosed.

Reporting Considerations

If the estimated loss arising from alleged malpractice is accrued for and disclosed in conformity with the provisions of paragraphs 8 through 11 of FASB Statement No. 5 and FASB Interpretation No. 14, and if there is no material exposure to losses from claims and potential claims in excess of the amount accrued, or if all claims and potential claims are adequately covered by insurance, the auditor should not modify his report with respect to such claims.

Statement on Auditing Standards No. 2, paragraph 15, states that the auditor should express a qualified or an adverse opinion when financial statements examined in accordance with generally accepted auditing standards are materially affected by a departure from generally accepted accounting principles. The following is an

[4] See page 5 of the *Hospital Audit Guide* for the discussion, "Third-Party Reimbursement Timing Differences."

example of a modification of the auditor's report, along with an example of appropriate financial statement disclosure, when a hospital makes a provision for malpractice losses that is materially different from the amount that should be accrued under FASB Statement No. 5 and FASB Interpretation No. 14.

(Scope Paragraph—Standard Wording)
(Separate Paragraph)

As described in Note X, claims for alleged malpractice in excess of insurance coverage have been asserted against the hospital by various claimants, and additional material claims may be asserted arising from services provided to patients in the past. The hospital has charged income with a provision of $_____ for losses related to uninsured malpractice claims. The ultimate liability of the hospital resulting from such claims is not presently determinable. Generally accepted accounting principles preclude a charge to income for a provision for loss contingencies that cannot be reasonably estimated.

(Opinion Paragraph)

In our opinion, except for the effect of recording a provision for losses related to malpractice claims which cannot be reasonably estimated, the financial statements referred to above present fairly . . . in conformity with generally accepted accounting principles. . . .

(Financial Statement Disclosure)

Malpractice claims in excess of insurance coverage have been asserted against the hospital by various claimants, and additional claims may be asserted for known incidents through (balance sheet date). The claims are in various stages of processing and some may ultimately be brought to trial. Counsel is unable to conclude about the ultimate outcome of the actions commenced. Moreover, additional material claims arising from services provided to patients in the past may be asserted. The hospital is unable to estimate the ultimate cost of the settlement of such potential claims. Although the amount of the losses from uninsured malpractice claims cannot be reasonably estimated, the hospital considers it prudent to record a provision for such losses and accordingly has charged income with a provision of $_____.

The auditor should consult relevant statements on auditing standards to determine the need, if any, for otherwise modifying his report because of malpractice contingencies.

APPENDIX C

Statement of Position 78-1

ACCOUNTING BY HOSPITALS FOR CERTAIN MARKETABLE EQUITY SECURITIES

May 1, 1978

Proposal to Financial Accounting Standards Board to Amend AICPA Industry Audit Guide on Audits of Hospitals

Issued by Accounting Standards Division
American Institute of Certified Public Accountants

NOTICE TO READERS

The American Institute of Certified Public Accountants has issued a series of industry-oriented audit guides that present recommendations on auditing procedures and auditors' reports and, in some instances, on accounting principles, and a series of accounting guides that present recommendations on accounting principles. Based on experience in the application of these guides, AICPA subcommittees or task forces may from time to time conclude that it is desirable to change a guide. A statement of position is used to revise or clarify certain of the recommendations in the guide to which it relates. A statement of position represents the considered judgment of the responsible AICPA subcommittee or task force.

To the extent that a statement of position is concerned with auditing procedures and auditors' reports, its degree of authority is the same as that of the audit guide to which it relates. As to such matters, members should be aware that they may be called upon to justify departures from the recommendations of the subcommittee or task force.

To the extent that a statement of position relates to standards of financial accounting or reporting (accounting principles), the recommendations of the subcommittee or task force are subject to ultimate disposition by the Financial Accounting Standards Board. The recommendations are made for the purpose of urging the FASB to promulgate standards that the subcommittee or task force believes would be in the public interest.

Subcommittee on Health Care Matters

ALBERT A. CARDONE, *Chairman*
RONALD B. ASHWORTH
MARVIN E. BAKER
CHARLES K. BRADFORD
JOHN E. BUELT
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The subcommittee gratefully acknowledges the contributions made to the development of this Statement of Position by former members of the subcommittee, Robert A. Cerrone, William Freitag, and Robert F. Rosenstiel.

AICPA American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, N.Y.10036 (212) 575-6200

May 1, 1978

Donald J. Kirk, CPA
Chairman
Financial Accounting Standards Board
High Ridge Park
Stamford, Connecticut 06905

Dear Mr. Kirk:

The accompanying statement of position, prepared by the AICPA Subcommittee on Health Care Matters, proposes amendments to the AICPA Industry Audit Guide on Audits of Hospitals. The statement of position will amend part of chapter 2 of the guide which deals with investment income and gains (losses).

Members of the subcommittee will be glad to meet with you or your representatives to discuss this proposal. The subcommittee would also appreciate being advised as to the board's proposed action on its recommendations.

Sincerely yours,

Albert A. Cardone

Albert A. Cardone, Chairman
Subcommittee on Health
Care Matters

Accounting by Hospitals for Certain Marketable Equity Securities

Statement of Financial Accounting Standards no. 12, *Accounting for Certain Marketable Securities,* issued by the Financial Accounting Standards Board, states in the first sentence of paragraph 5 that it "does not apply to not-for-profit organizations," which are those described in the Introduction to Accounting Research Bulletin no. 43. Thus, FASB Statement no. 12 applies to investor-owned hospitals and does not apply to not-for-profit hospitals.

The AICPA Subcommittee on Health Care Matters believes that the *Hospital Audit Guide* should be amended by deletion of the section "Investment Income and Gains (Losses)" and inclusion of the following new section.

Accounting for Certain Marketable Equity Securities

Investor-owned hospitals are subject to the requirements of FASB Statement no. 12 and interpretations of that statement, which specify the accounting and disclosure requirements applicable to portfolios of marketable equity securities. Under statement no. 12, cost is no longer an acceptable accounting method for marketable equity securities, and the carrying amount of a marketable equity security portfolio that was previously carried at cost should now be the lower of its aggregate cost and market values.[1]

Similarly, cost should no longer be used by not-for-profit hospitals for marketable equity securities. The carrying amount of a mar-

[1] Reference should be made to paragraph 7 of FASB Statement no. 12 for definitions of the following terms: equity security, marketable, market price, market value, cost, valuation allowance, carrying amount, realized gain or loss, net unrealized gain or loss.

ketable equity security portfolio of a not-for-profit hospital that was previously carried at cost should now be the lower of its aggregate cost and market value, determined at the balance sheet date. The amounts by which the aggregate cost of each portfolio exceeds market value should be accounted for as valuation allowances.

Marketable equity securities owned by a not-for-profit hospital should be grouped into separate portfolios, as indicated below, for the purpose of comparing aggregate cost and market value to determine carrying amount.

1. Marketable equity securities included in unrestricted funds should be grouped into separate portfolios according to the current or noncurrent classification of the securities.
2. Marketable equity securities included in different types of restricted funds should be grouped into separate portfolios according to types of funds (for example, portfolios of marketable equity securities included in various specific purpose funds should be grouped together but not with those in endowment funds).
3. The current portfolios of unrestricted funds of entities that are combined in financial statements should be treated as a single combined portfolio; the noncurrent unrestricted portfolios of those entities shcuild also be treated as a single combined portfolio; similar restricted fund portfolios of entities that are combined in financial statements should be treated as single portfolios (for example, portfolios of marketable equity securities included in the various specific purpose funds of a not-for-profit hospital should be combined with the portfolios of marketable equity securities held in the various specific purpose funds of an entity whose financial statements are combined with those of the not-for-profit hospital).

If there is a change in a marketable equity security's classification between current and noncurrent assets in unrestricted funds, the security should be transferred between the corresponding portfolios at the lower of its cost and market values at the date of transfer. If market value is less than cost, the market value becomes

the new cost basis, and the difference is accounted for as if it were a realized loss and is included in the nonoperating revenues section of the statement of revenues and expenses.

Changes in the valuation allowance for a marketable equity securities portfolio included in current assets in unrestricted funds should be disclosed in the nonoperating revenues section of the statement of revenues and expenses. Changes in the valuation allowance for a marketable equity securities portfolio included in noncurrent assets in unrestricted funds or assets in restricted funds should be disclosed in the respective statements of changes in fund balances; accumulated changes in the valuation allowance for such portfolios should be disclosed in the appropriate fund balance in the balance sheet.

If the hospital pools its investments (which could include investments of current and noncurrent unrestricted funds and investments of restricted funds), the cost of marketable equity securities in the fund(s) should be compared to the allocation of the market value of the pooled marketable equity securities for purposes of implementing the above recommendations. To apply those provisions properly, marketable equity securities and other investments must be accounted for separately.

Income from investments of board-designated and other unrestricted funds and realized gains or losses on sales of investments of board-designated and other unrestricted funds should be included in the statement of revenues and expenses as nonoperating revenue of the period in which they are earned or incurred.

Realized gains or losses on the sale of investments of endowment funds should be added to or deducted from endowment fund principal unless such amounts are legally available for other use or chargeable against other funds. Investment income of those funds should be accounted for in accordance with the donors' instructions—for example, as resources for specific operating purposes if restricted, or nonoperating revenue if not.

Income and net realized gains or losses on investments of restricted funds other than endowment funds should be charged or credited to the respective fund balance unless such amounts are legally available for or chargeable against other funds. If such amounts are legally available for unrestricted purposes, they should

be included in nonoperating revenue. Gains or losses on investment trading between unrestricted and restricted funds and between various categories of restricted funds (for example, between endowment and plant replacement funds) should be recognized as realized gains or losses and separately disclosed in the financial statements. Gains or losses resulting from transactions between various board-designated funds of the unrestricted fund should not be recognized.

The following information with respect to owned marketable equity securities should also be disclosed either in the body of the financial statements or in the accompanying notes:

1. As of the date of each balance sheet presented, aggregate cost and market values for each separate portfolio into which marketable equity securities were grouped to determine carrying amount, with identification of which is the carrying amount.
2. As of the date of the latest balance sheet presented, the following segregated by portfolio—
   a. Gross unrealized gains representing the excess of market value over cost for all marketable equity securities having such an excess in the portfolio.
   b. Gross unrealized losses representing the excess of cost over market value for all marketable equity securities having such an excess in the portfolio.
3. For each period for which a statement of revenues and expenses is presented—
   a. Net realized gain or loss included in nonoperating revenue.
   b. The basis on which cost was determined in computing realized gain or loss (average cost or other method).

The financial statements should not be adjusted for realized gains, losses, or changes in market prices with respect to marketable equity securities if such gains, losses, or changes occur after the date of the financial statements but before their issuance, except for the situation covered in the following paragraph. However, significant net realized and net unrealized gains and losses arising after the date of the financial statements but before their issuance applicable to marketable equity securities owned at the date of the most recent balance sheet should be disclosed.

For those marketable securities for which the effect of a change in carrying amount is included in the statement of changes in fund balances rather than in the statement of revenues and expenses, a determination should be made as to whether a decline in market value below cost as of the balance sheet date of an individual security is other than temporary. If the decline is judged to be other than temporary, the cost basis of the individual security should be written down to a new cost basis and the amount of the write-down should be accounted for as a realized loss. The new cost basis should not be changed for subsequent recoveries in market value.

Unrealized gains or losses should not result in adjustment of financial statements, except for changes in the valuation allowance related to marketable equity securities and for declines in value that result from other than temporary impairment.

The disclosures in Note 1 to the sample financial statements on page 48 of the *Hospital Audit Guide* should conform with the disclosures set forth in this amendment.

Transition

The subcommittee recommends that this amendment be applied to financial statements for fiscal years beginning on or after the first day of the first month following the date of this statement and encourages earlier application. If the initial application of this statement requires the establishment of a valuation allowance, financial statements previously issued should not be restated. If the establishment of a valuation allowance is required for a marketable equity securities portfolio included in current assets in unrestricted funds, the effect of the change should be included in the determination of the excess of revenue over expense for the period of the change in accordance with the provisions of APB Opinion 20. If the establishment of a valuation allowance is required for a marketable equity securities portfolio included in noncurrent assets in unrestricted funds or assets in restricted funds, the effect of the change should be presented in the statement of changes in fund balance.

APPENDIX D

Statement of Position 78-7 on FINANCIAL ACCOUNTING AND REPORTING BY HOSPITALS OPERATED BY A GOVERNMENTAL UNIT

JULY 31, 1978

Proposal to Financial Accounting Standards Board
to Amend AICPA Industry Audit Guide on
Audits of State and Local Governmental Units

Issued by Accounting Standards Division
American Institute of Certified Public Accountants

NOTES

Statements of position of the accounting standards division are issued for the general information of those interested in the subject. They present the conclusions of at least a majority of the accounting standards executive committee, which is the senior technical body of the Institute authorized to speak for the Institute in the areas of financial accounting and reporting and cost accounting.

The objective of statements of position is to influence the development of accounting and reporting standards in directions the division believes are in the public interest. It is intended that they should be considered, as deemed appropriate, by bodies having authority to issue pronouncements on the subject. However, statements of position do not establish standards enforceable under the Institute's code of professional ethics.

AICPA American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, N.Y.10036 (212) 575-6200

July 31, 1978

Donald J. Kirk, CPA
Chairman
Financial Accounting Standards Board
High Ridge Park
Stamford, Connecticut 06905

Dear Mr. Kirk:

The accompanying statement of position, Financial Accounting and Reporting by Hospitals Operated by a Governmental Unit, has been prepared by the accounting standards division.

The statement is an amendment of the AICPA Industry Audit Guide, Audits of State and Local Governmental Units, issued in 1974 and presents the division's recommendation for the accounting and reporting by hospitals operated by a governmental unit.

Representatives of the division are available to discuss this proposal with you or your representatives at your convenience.

Sincerely,

Arthur R. Wyatt

Arthur R. Wyatt, Chairman
Accounting Standards Division

cc: Securities and Exchange Commission

Accounting Standards Division

Accounting Standards Executive Committee

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Financial Accounting and Reporting by Hospitals Operated by a Governmental Unit

The AICPA Industry Audit Guide, *Hospital Audit Guide,* does not specifically address the financial accounting and reporting practices of hospitals that are operated by a governmental unit but states that the practices it discusses apply to all hospitals. The AICPA Industry Audit Guide, *Audits of State and Local Governmental Units,* effectively includes government operated hospitals within its scope. That overlap has raised questions concerning the financial accounting and reporting practices that should be followed by hospitals operated by governmental units.

Different views exist about whether the financial activities of a hospital operated by a governmental unit should be accounted for as an enterprise fund or as a special revenue fund. Hospitals accounted for as enterprise funds usually follow practices comparable to those discussed in the *Hospital Audit Guide,* and hospitals accounted for as special revenue funds follow the practices discussed in *Audits of State and Local Governmental Units.* Since these accounting practices differ significantly, the accounting standards division believes that *Audits of State and Local Governmental Units* should be amended to provide for uniformity in the financial reporting of hospitals.

The Division's Conclusion

Some government operated hospitals have been accounted for as special revenue funds and others as enterprise funds, depending on the source of funding. The accounting standards division believes, however, that the source of revenues should not determine the accounting practices followed by hospitals. If all government operated hospitals followed the *Hospital Audit Guide* and were accounted for as enterprise funds, more comparable financial statements within the hospital industry would result. The division therefore believes that *Audits of State and Local Governmental Units* should be amended by the addition of

the following paragraph (and its accompanying footnote) as the first full paragraph on page 14 of the guide.

> Hospitals that are operated by governmental units should follow the requirements of the AICPA's *Hospital Audit Guide*. Since the accounting recommended in that guide can best be accommodated in the enterprise funds, such funds should be used in accounting for governmental hospitals.*

*See page 1 of the *Hospital Audit Guide* for a discussion of the types of hospitals covered.

Transition

This statement should be applied for fiscal years beginning after June 30, 1979. Earlier application of the statement of position is encouraged. The recommendations should be applied retroactively by prior-period adjustments, that is, reflected as adjustments of opening fund balances of the earliest years presented. When financial statements for periods before June 30, 1979, are presented, they should be restated to reflect the prior-period adjustments. The nature of the restatements and their effects should be disclosed in the period of change.

APPENDIX E

Statement of Position 81-2

Reporting Practices Concerning Hospital-Related Organizations

August 1, 1981

Proposal to the
Financial Accounting Standards Board
to Amend AICPA Industry Audit Guide
Hospital Audit Guide

Issued by
Accounting Standards Division
American Institute of
Certified Public Accountants

AICPA

NOTE

The American Institute of Certified Public Accountants has issued a series of industry-oriented audit guides that present recommendations on auditing procedures and auditors' reports and, in some instances, on accounting principles, and a series of accounting guides that present recommendations on accounting principles. Based on experience in the application of these guides, AICPA committees, subcommittees, or task forces may from time to time conclude that it is desirable to change a guide. A statement of position is used to revise or clarify certain of the recommendations in the guide to which it relates. A statement of position represents the considered judgment of the responsible AICPA committee, subcommittee, or task force.

To the extent that a statement of position is concerned with auditing procedures and auditors' reports, its degree of authority is the same as that of the audit guide to which it relates. As to such matters, members should be aware that they may be called upon to justify departures from the recommendations of the committee, subcommittee, or task force.

To the extent that a statement of position relates to standards of financial accounting or reporting (accounting principles), the recommendations of the committee, subcommittee, or task force are subject to ultimate disposition by the Financial Accounting Standards Board. The recommendations are made for the purpose of urging the FASB to promulgate standards that the committee, subcommittee, or task force believes would be in the public interest.

Reporting Practices Concerning Hospital-Related Organizations

1. In recent years there has been an increasing trend toward the creation of separate organizations, frequently referred to as foundations, to raise and hold certain funds for hospitals.

2. Those organizations appear to have been created to broaden the philanthropic base of hospitals and to preserve discretionary funds to support desired programs. There is a growing fear that governmental programs and controls will require the expenditure of such funds to subsidize nondiscretionary services. Organizers of separate fund-raising entities hope that exposure of the funds to such threats may be avoided, or at least lessened, by the use of separate organizations.

3. Some people believe that the financial statements of the separate organizations should not be combined with those of the related hospitals because combining them would result in a requirement to use contributed discretionary funds to defray a portion of the costs of care for patients who are covered by programs such as Medicare, Medicaid, and Blue Cross. Others share that concern but believe that it should be dealt with independently of accounting considerations and that accounting and reporting should be determined without reference to those potential effects.

4. There is also concern that, if the form of the combination reflects the unrestricted resources of the related organization as unrestricted resources of the hospital, the difference in the availability of the related organization's resources because of its separate legal status would not be clearly disclosed.

5. The AICPA's *Hospital Audit Guide* presently calls for combined financial reporting for related organizations "if significant re-

sources or operations of a hospital are handled by such organizations . . . [and they] are under control of (or common control with) hospitals. . . . " However, the guide does not give sufficient guidance about what constitutes "control" or "hospital resources." As a consequence, a variety of reporting practices are being followed, and the financial statements of some related organizations are combined with those of hospitals while the financial statements of other organizations in similar circumstances are not. The related facts and circumstances sometimes are disclosed and sometimes are not.

6. Because of the variety of current reporting practices, the subcommittee on health care matters believes that the *Hospital Audit Guide* should be clarified in this area.

Subcommittee's Conclusions

7. The subcommittee on health care matters believes that the section of the *Hospital Audit Guide*, 3d ed. (1980), under "Other Related Organizations" (pages 11 and 12) should be superseded by the following paragraphs.

8. Foundations, auxiliaries, guilds, and similar organizations frequently assist and, in many instances, are related to hospitals. Accounting Research Bulletin no. 51, *Consolidated Financial Statements*, provides guidance on whether the financial statements of related organizations should be consolidated or combined. Page 3 of the *Hospital Audit Guide* indicates the applicability of Accounting Research Bulletins to hospitals.

9. Not-for-profit hospitals may be related to one or more separate not-for-profit organizations. For purposes of this statement of position, a separate organization is considered to be related to a hospital[1] if

a. The hospital controls the separate organization through contracts or other legal documents that provide the hospital with the authority to direct the separate organization's activities, management, and policies; *or*

[1]This paragraph presents criteria for determining whether such an organization is a hospital-related organization for the purposes of this statement of position. SAS No. 6, *Related Party Transactions*, discusses the auditor's responsibilities concerning related parties in general.

b. The hospital is for all practical purposes the sole beneficiary of the organization. The hospital should be considered the organization's sole beneficiary if any one of the three following circumstances exist:

1. The organization has solicited funds in the name of the hospital, and with the expressed or implied approval of the hospital, and substantially all the funds solicited by the organization were intended by the contributor, or were otherwise required, to be transferred to the hospital or used at its discretion or direction.
2. The hospital has transferred some of its resources to the organization, and substantially all of the organization's resources are held for the benefit of the hospital.
3. The hospital has assigned certain of its functions (such as the operation of a dormitory) to the organization, which is operating primarily for the benefit of the hospital.

10. If the condition described in subparagraph 9*a* and at least one of the conditions described in subparagraph 9*b* are satisfied, and if the financial statements of the hospital and the related organizations are not consolidated or combined in accordance with paragraph 8, then the hospital's financial statements should disclose information concerning the related organizations. The hospital should present summarized information about the assets, liabilities, results of operations, and changes in fund balances of the related organizations in the notes to the hospital's financial statements and should clearly describe the nature of the relationships between the hospital and the related organizations. (Appendix A illustrates this disclosure.) When a related organization makes its assets available to the hospital, the hospital should account for them in accordance with the terms and conditions prescribed by the related organization.

11. There may be instances in which the items presented in the financial statements of the related organization are not consolidated, combined, or disclosed in accordance with the requirements of paragraph 10 because they do not meet the conditions described in the preceding paragraphs. If a related organization holds material amounts of funds that have been designated for the benefit of the hospital, or if there have been material transactions between the hospital and the related organization, the hospital's financial statements should disclose the existence and nature of the relationship

between the hospital and the related organization. Further, if there have been material transactions between the hospital and the related organization during the periods covered by the hospital's financial statements, the following should also be disclosed:

a. A description of the transactions, summarized if appropriate, for the period reported on, including amounts, if any, and any other information deemed necessary to an understanding of the effects on the hospital's financial statements.

b. The dollar volume of transactions and the effects of any change in the terms from the preceding period.

c. Amounts due from or to the related organization, and, if not otherwise apparent, the terms and manner of settlement.

12. Appendix B illustrates the foregoing disclosures for a not-for-profit hospital that, during the year, received substantial amounts of contributions from a not-for-profit community health fund-raising organization that is controlled by the hospital but that also raises funds for other health-related organizations in the community. Similar information would also be disclosed in situations in which the hospital does not control the separate organization but is its sole beneficiary, as described in subparagraph 9*b*, and there have been material transactions during the year between the hospital and the separate organization.

Transition

13. This statement of position should be applied in financial statements for fiscal years beginning on or after July 1, 1981, although earlier application is encouraged. Accounting changes adopted to apply the recommendations of this statement of position should be made retroactively by restating the financial statements of prior periods.

APPENDIX A

Note — Sample Hospital Foundation

Note: Appendix A illustrates the disclosure by a not-for-profit hospital that is considered to be related to a separate not-for-profit organization because the hospital controls it and is deemed to be its sole beneficiary, as described in paragraph 9 of the SOP.

Sample Hospital Foundation (the foundation) was established to raise funds to support the operation of Sample Hospital. The foundation's bylaws provide that all funds raised, except for funds required for operation of the foundation, be distributed to or be held for the benefit of the hospital. The foundation's bylaws also provide the hospital with the authority to direct its activities, management, and policies. The foundation's general funds, which represent the foundation's unrestricted resources, are distributed to the hospital in amounts and in periods determined by the foundation's board of trustees, who may also restrict the use of general funds for hospital plant replacement or expansion or other specific purposes. Plant replacement and expansion funds, specific-purpose funds, and assets obtained from income from endowment funds of the foundation are distributed to the hospital as required to comply with the purposes specified by donors. A summary of the foundation's assets, liabilities and fund balances, results of operations, and changes in fund balances follows.

	19X1	*19X0*
	(in thousands)	
Assets	$11,118	$10,265
Liabilities [1]	$ 1,046	$ 1,025
Fund balances		
Unrestricted	3,525	3,230
Restricted	6,547	6,010
Total fund balances	10,072	9,240
Total liabilities and fund balances	$11,118	$10,265

	19X1	*19X0*
	(in thousands)	
Support and revenue	$ 4,867	$ 4,240
Expenses		
Distributions to Sample Hospital[2]	4,154	3,112
Other	228	320
Total expenses	4,382	3,432
Excess of support and revenue over expenses	485	808
Other changes in fund balances	347	112
Fund balance, beginning of year	9,240	8,320
Fund balance, end of year	$10,072	$ 9,240

1. Includes $1 million payable at the end of each year to Sample Hospital. These amounts were paid after the end of each year.
2. The distributions by the foundation to Sample Hospital are included in the hospital's financial statements as follows.

	19X1	*19X0*
	(in thousands)	
Unrestricted grants and contributions	$1,404	$ 912
Restricted grants for specific purposes	250	200
Plant replacement and expansion	2,500	2,000
	$4,154	$3,112

APPENDIX B

Note — Related-Party Transactions

Note: Appendix B illustrates the disclosure by a not-for-profit hospital that is considered to be related to a separate not-for-profit organization because it controls the separate organization but is not its sole beneficiary, as described in paragraph 9 of the SOP. There were also material transactions between the hospital and the related organization.

Because of the existence of common trustees and other factors, ABC Hospital controls Community Health Foundation (the foundation). The foundation is authorized by ABC Hospital to solicit contributions on its behalf. In its general appeal for contributions to support the community's providers of health care services, the foundation also solicits contributions for certain other health care institutions. In the absence of donor restrictions, the foundation has discretionary control over the amounts to be distributed to the providers of health care services, the timing of such distributions, and the purposes for which such funds are to be used.

The contributions made by the foundation to the hospital during the year ended December 31, 19X1 and 19X0, are included in the hospital's financial statements as follows.

	19X1	*19X0*
Unrestricted contributions	$150,000	$150,000
Restricted contributions for		
Specific purposes	35,000	25,000
Plant replacement and expansion purposes	25,000	50,000
Endowment purposes	50,000	150,000

APPENDIX C

Summary of Requirements of the Hospital

	Circumstances	*Requirements*
1.	The hospital is related to a separate organization and meets the criteria stated in ARB no. 51.	Consolidate or combine in accordance with ARB no. 51.
2.	The hospital does not meet the criteria stated in ARB no. 51 but controls *and* is the sole beneficiary of the related organization's activities.	In a note to the financial statements, disclose summarized financial data of the related organization, such as total assets, total liabilities, changes in fund balances, total revenue, total expenses, and amount of distributions to the hospital; and disclose the nature of the relationship between the hospital and the related organization.
3.	Neither of the above is present, but the related organization holds significant amounts of funds designated for the hospital.	Disclose the existence and nature of the relationship.
4.	There have been material transactions between the hospital and the related organization. (This could be present in any of the above circumstances.)	In the notes to the financial statements, (a) disclose the existence and nature of the relationship and (b) describe and quantify the transactions.

Accounting Standards Division

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The subcommittee gratefully acknowledges the contributions made to the development of this statement of position by former members of the subcommittee:

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APPENDIX F

Statement of Position 85-1

Financial Reporting by Not-for-Profit Health Care Entities for Tax-Exempt Debt and Certain Funds Whose Use Is Limited

January 1, 1985

Amendment to
AICPA Industry Audit Guide
Hospital Audit Guide

Issued by
Accounting Standards Division

American Institute of
Certified Public Accountants

AICPA

NOTE

This statement of position amends the AICPA Industry Audit Guide, *Hospital Audit Guide*.

Statements of position of the Accounting Standards Division present the conclusions of at least a majority of the Accounting Standards Executive Committee, which is the senior technical body of the Institute authorized to speak for the Institute in the areas of financial accounting and reporting. Statements of position do not establish standards enforceable under rule 203 of the Institute's Code of Professional Ethics. However, Statement on Auditing Standards (SAS) No. 5, *The Meaning of "Present Fairly in Conformity With Generally Accepted Accounting Principles" in the Independent Auditor's Report*, as amended by SAS No. 43, *Omnibus Statement on Auditing Standards*, identifies AICPA statements of position as another source of established accounting principles the auditor should consider. Accordingly, members should be prepared to justify departures from the recommendations in this statement of position.

Table of Contents

SUMMARY

This statement of position provides guidance for not-for-profit health care entities (a) reporting long-term debt issued through a financing authority, (b) classifying funds whose use is limited as either general (unrestricted) or restricted, and (c) reporting related investment income and interest expense in the financial statements.

The statement recommends the following:

- Unrestricted funds should be called general funds (as defined) and health care entities should report, as liabilities in the general funds section of the balance sheet, debt issued for their benefit and for repayment of which they are responsible when the debt is issued.
- Only assets restricted by a donor or by a grantor should be reported in the donor-restricted funds section of the balance sheet. Other assets should be reported in the general funds section.
- Assets whose use is limited in substance under terms of debt indentures, trust agreements, third-party reimbursement arrangements, or other similar arrangements should be reported in the general funds section as assets whose use is limited.
- Interest expense and investment income on borrowed funds held by a trustee (to the extent they are not capitalized) should be reported separately as operating expense or operating revenue, respectively, or alternatively, may be netted and reported as operating expense or operating revenue with the offsetting amount disclosed parenthetically. Investment income related to funds whose use is limited under third-party reimbursement arrangements (funded depreciation) and funds held by a trustee that are not borrowed funds should be reported as nonoperating revenue.

The provisions of this statement are effective for periods beginning on or after January 1, 1985.

Financial Reporting by Not-for-Profit Health Care Entities for Tax-Exempt Debt and Certain Funds Whose Use Is Limited

Introduction and Scope

1. Increased construction costs of health care facilities, resulting from rising prices and a decline in philanthropy and government grants as sources of capital, have caused health care entities to finance facilities acquisitions, additions, and renovations with long-term debt.

2. Issuance of tax-exempt or taxable bonds are among the long-term financing alternatives available to health care entities. Approximately three-fourths of all health care entity debt instruments issued in recent years have been tax-exempt bonds, generally revenue bonds. Tax-exempt bonds can usually be issued to obtain a higher ratio of project financing (up to 100 percent), a longer maturity period (up to thirty years), and a lower interest cost than taxable bonds.

3. Because many hospitals cannot legally issue tax-exempt revenue bonds directly, a significant number of states have enacted legislation permitting health care entities to borrow funds for capital projects by issuing bonds through financing authorities. Financing authorities are authorized to issue tax-exempt bonds or other obligations and use the proceeds for the benefit of the health care entities. To obtain project financing, a health care entity is sometimes required by a financing authority to enter into a lease arrangement or sublease arrangement or both. At other times a lease or sublease arrangement is not required. In either case a liability is recorded in the health care entity's balance sheet.

4. In the absence of definitive guidance, diverse reporting practices related to funds whose use is limited under those financing arrangements, or under third-party reimbursement arrangements, have developed in the health care industry. The Accounting Stand-

ards Division believes that specific guidance is needed to achieve uniform reporting practices for —

- Long-term debt issued through financing authorities for the benefit of health care entities, repayment of which is the entities' responsibility.
- Funds whose use is limited under the terms of debt-financing agreements.
- Investment income earned on funds whose use is limited under debt-financing agreements and the interest expense on the debt.
- Funds whose use is limited under third-party reimbursement arrangements and related investment income.

5. This statement addresses the reporting of tax-exempt bonds or other tax-exempt obligations issued through financing authorities to finance the facilities of not-for-profit health care entities, which are responsible for repayment of the bonds. It also addresses issues related to the reporting of funds established under the terms of debt-financing instruments and of the investment (interest) income and expense on such funds, neither of which is addressed by the AICPA Industry Audit Guide, *Hospital Audit Guide*.

6. In addition, this statement modifies the reporting of funds whose use, under third-party reimbursement arrangements, is limited to such purposes as replacements or additions to property, plant, and equipment. Those funds are addressed in the *Hospital Audit Guide*.

Definitions

7. The following definitions apply for purposes of this statement.

Assets (Funds) Whose Use Is Limited. Assets whose use is limited appear in the general (unrestricted) funds section of the balance sheet and include —

- Assets set aside by the governing board for identified purposes and over which the board retains control and may, at its discretion, subsequently use for other purposes.

- Proceeds of debt issues and funds of the health care entity deposited with a trustee and limited to use in accordance with the requirements of an indenture or similar document.
- Other assets limited to use for identified purposes through an agreement between the health care entity and an outside party other than a donor or grantor.

Donor-Restricted Funds. Funds restricted for specific purposes by donors or grantors, for example, endowment funds or funds restricted to plant replacement and expansion.

General Funds. See paragraphs 8, 9, and 10.

Indenture. An agreement between two or more persons specifying the reciprocal rights and duties of the parties under a contract, such as a lease, mortgage, or contract between bondholders and the issuer of the bond.

Revenue Bonds. Bonds generally issued by a financing authority for the benefit of a health care entity and secured by a pledge of the entity's revenues.

8. A health care entity's resources and obligations are generally segregated into logical account groups based on external restrictions (restricted funds) or administrative requirements (unrestricted or general funds). Unrestricted funds are used for general operating purposes and reflect those resources or obligations that are not restricted by donors or grantors.

9. Classifying funds whose use is limited under terms of debt-financing agreements or third-party reimbursement agreements as unrestricted funds is often confusing to readers of a health care entity's financial statements because the readers may infer that the limitations require the funds to be classified as restricted rather than unrestricted. However, as discussed further in this statement, only funds restricted by a donor or a grantor should be reported as donor-restricted funds; other funds should be reported as general funds.

10. Although the term "unrestricted funds" has been used historically to identify those funds that are not restricted by donors or grantors, the caption "unrestricted funds" should be changed to

"general funds" because this term is more meaningful to readers of financial statements. The term "unrestricted funds" in the *Hospital Audit Guide* should be replaced with the term "general funds" and be defined as follows:

> *General Funds.* Funds not restricted for identified purposes by donors or grantors, including resources that the governing board may use for any designated purpose and resources whose use is limited by agreement between the health care entity and an outside party other than a donor or grantor.

The Basic Issues

11. Not-for-profit health care entities face the following reporting issues related to tax-exempt debt and funds whose use is limited under a debt-financing agreement or a third-party reimbursement arrangement.

a. How and when should a health care entity report long-term debt issued for its benefit and for which it is responsible for repayment in full?

b. Should funds whose use is limited under the terms of an indenture agreement or a third-party reimbursement arrangement be classified on the balance sheet as general (unrestricted) or as restricted funds?

c. How should related investment income and interest expense be reported in the financial statements?

Issues associated with the accounting for board-designated assets are discussed adequately in the *Hospital Audit Guide.*

Diversity in Practice

12. When a financing authority issues tax-exempt bonds or similar debt instruments and uses the proceeds for the benefit of a health care entity, some entities report the obligation in the general (unrestricted) funds section of the balance sheet. Others report the obligation in the restricted funds section of the balance sheet.

13. Reporting practices also differ for funds whose use is limited or for funds that are required by terms of an indenture agreement to

be held by trustees for construction costs, debt service reserve payments, and other costs related to the project. Some entities report those funds as assets of the restricted funds. Others report them as noncurrent assets in the general (unrestricted) funds section of the balance sheet. Others net the assets with the corresponding debt, reporting the net amount either in the general (unrestricted) fund or in the restricted fund and disclosing in a note to the financial statements the amounts the indenture requires to be held by bond trustees for debt service payments and other purposes.

14. In addition to the variety of asset reporting practices described above, several methods are used to report the related investment income and interest expense in the statement of revenues and expenses. Some entities report investment income and interest expense either in the operating or in the nonoperating revenues and expenses sections. Others report net investment income or expense as either operating or nonoperating revenue or operating or nonoperating expense. If the assets have been reported as restricted funds, others report the related investment income as an addition to the restricted fund balance.

15. With respect to funds whose use is limited under third-party reimbursement arrangements, Medicare regulations encourage, but do not require, that hospitals fund depreciation by setting aside cash or other liquid assets in a separate fund account to be used for the acquisition or replacement of depreciable assets. Some Blue Cross plans and some state Medicaid programs reimburse hospitals for depreciation only if it is funded. However, most Blue Cross plans and Medicaid programs do not require funding as a prerequisite for depreciation reimbursement. In addition, some state regulations may require assets to be set aside for capital improvements or other purposes. Some health care entities report assets representing funded depreciation or assets set aside for capital improvements or other purposes in the board-designated (noncurrent) section of the general (unrestricted) fund balance sheet. Others report them in the restricted fund section of the balance sheet. The related income from investing those assets is reported either in the statement of revenues and expenses or in the restricted fund balance, respectively.

Views on the Issues

Classifying the Debt

16. Some believe that when a financing authority issues tax-exempt bonds or similar debt instruments and uses the proceeds for the benefit of a health care entity, the debt should be reported as an obligation in the general (unrestricted) funds section of the entity's balance sheet. They hold this view because any limitations on the use of the proceeds are imposed by the voluntary action of the governing board. Others believe that the debt should be reported in the restricted funds section of the balance sheet because, generally, the proceeds of the bond issue are administered under the terms of the indenture by an independent trustee. Since the proceeds are limited to use for project costs, they consider them to be restricted and, therefore, the related debt should also be restricted.

Classifying Assets Whose Use Is Limited

17. Some believe that funds whose use is limited by terms of an indenture agreement or by a third-party reimbursement agreement should be reported in the restricted funds section of the balance sheet, since under the terms of the contract or agreement, such funds cannot be used for other purposes.

18. Others hold, however, that restricted funds should be used only to account for funds restricted by donors or by grantors (a treatment consistent with the *Hospital Audit Guide*) and that general (unrestricted) funds should be used to account for all other resources. They believe that, although donor restrictions are common in health care entities, debt-financing instruments that contain contract limitations on the use of funds are not unique to health care entities but are prevalent throughout American industry. Such financing agreements or third-party reimbursement agreements are normal and recurring business activities that are necessary for carrying out the organization's objectives and are entered into at the discretion of the governing board and are related to the general (unrestricted) business operations of the entity. Thus, they believe that funds whose use is limited under terms of an indenture agreement or a third-party reimbursement agreement should be reported, with appropriate disclosure, as noncurrent assets in the

general (unrestricted) funds section of the balance sheet; they do not support reporting those assets in the restricted funds section of the balance sheet.

19. Those who net the assets with the corresponding debt during the construction period, either in the restricted or in the general (unrestricted) funds section, maintain that such treatment is preferable since the proceeds of the debt issue are limited to payment for the work in process.

Presenting Investment Income and Expense

20. Some believe that investment income and interest expense on borrowed funds held by a trustee should be reported separately in the operating section of the statement of revenues and expenses because such amounts are earned or incurred for operating purposes and are necessary to continue normal business operations. Others believe that such amounts should be netted because that treatment recognizes the economics of the transaction, namely, that income generated by the investment of the proceeds reduces the cost of borrowing. Either approach properly matches interest expense and the related investment income on borrowed funds, and each includes the net effect of borrowing in the results of operations.

21. Others report investment income on borrowed funds held by a trustee and on funded depreciation in the nonoperating section of the statement of revenues and expenses because they believe that this method is consistent with the AICPA *Hospital Audit Guide*, which recommends reporting income from investments of board-designated and other general (unrestricted) funds as nonoperating revenue.

22. Some report assets as restricted funds and the related investment income as an addition to the restricted fund balance because they consider investment income as an increase in the equity of the restricted funds.

Conclusions

23. Unrestricted funds should be called general funds (as defined in paragraphs 8, 9, and 10), and the following are the conclusions on the issues addressed in this statement:

a. Not-for-profit health care entities should report, as liabilities in the general funds section of the balance sheet, obligations issued for their benefit and for repayment of which they are responsible when the obligations are issued.

b. (1) Only assets restricted by a donor or by a grantor should be reported in the donor-restricted funds section of the balance sheet. Other assets should be reported in the general funds section of the balance sheet.

(2) Assets whose use is limited in substance under terms of debt indentures, trust agreements, third-party reimbursement arrangements, or other similar arrangements should be reported in the general funds section of the balance sheet as assets whose use is limited.

c. Interest expense and investment income on borrowed funds held by a trustee (to the extent they are not capitalized pursuant to FASB Statement of Financial Accounting Standards No. 62, *Capitalization of Interest Cost in Situations Involving Tax-Exempt Borrowings and Certain Gifts and Grants*) should be reported separately as operating expense or operating revenue, respectively, or alternatively, may be netted and reported as operating expense or operating revenue with the offsetting amount disclosed parenthetically. Investment income related to funds whose use is limited under third-party reimbursement arrangements (for example, funded depreciation) and general funds held by a trustee that are not borrowed funds should be reported as nonoperating revenue. If material, each amount should be reported separately.

Effective Date and Transition

24. This statement of position is effective for fiscal years beginning on or after January 1, 1985, with earlier application encouraged. Accounting changes and reclassifications adopted to conform to the provisions of this statement of position should be applied retroactively by restating the financial statements of prior periods.

APPENDIX

Illustrative Financial Statements

The following illustrate the financial statement presentation of the foregoing discussion. In addition, the accounting policies footnote would describe differences between general funds, including those limited as to use, and restricted funds.

Balance Sheet

Assets whose use is limited under the terms of an indenture agreement, through board designation or through an agreement between the health care entity and an outside party other than a donor or grantor should be reported below current assets in the general fund section of the balance sheet, as follows.

Exhibit 1

(Details of assets reported in the notes to the financial statement)

	General Fund	
	19X1	*19X0*
ASSETS WHOSE USE IS LIMITED (NOTES X AND Y)		
By board for capital improvements	$ 300,000	$ 100,000
By agreements with third-party payors	700,000	400,000
Under bond indenture agreement — held by trustee	3,000,000	2,000,000
Total assets whose use is limited	4,000,000	2,500,000
Less assets whose use is limited and that are required for current liabilities*	(500,000)	(500,000)
Noncurrent assets whose use is limited	$3,500,000	$2,000,000

*Contra amount reflected as a current asset of the general fund.

Exhibit 2

(Details of assets reported)

	General Fund	
	19X1	*19X0*
ASSETS WHOSE USE IS LIMITED (NOTES X AND Y)		
By board for capital improvements		
Investments	$ 300,000	$ 100,000
By agreements with third-party payors		
Cash	100,000	—
Investments	600,000	400,000
	$ 700,000	$ 400,000
Under bond indenture agreement — held by trustee		
Cash	$ 500,000	$ 400,000
Investments	2,500,000	1,600,000
	$3,000,000	$2,000,000
Total assets whose use is limited	$4,000,000	$2,500,000
Less assets whose use is limited and that are required for current liabilities*	(500,000)	(500,000)
Noncurrent assets whose use is limited	$3,500,000	$2,000,000

*Contra amount reflected as a current asset of the general fund.

Statement of Revenues and Expenses

Income on investments of assets whose use is limited, on board-designated assets, or on those assets whose use is limited in accordance with an agreement between the health care entity and an outside party other than a donor or grantor should be reported in the statement of revenues and expenses as shown in exhibits 3 and 4, based on the following assumptions.

Investment income from board-designated funds	$ 50,000
Investment income from assets whose use is limited	
Unexpended debt proceeds held by trustee under indenture agreement	75,000
Other assets held by trustee under indenture agreement[1]	100,000
Depreciation funds	150,000

(1) Includes investment income on funds held by trustee that were not generated through borrowed funds.

Exhibit 3

Investment income on unexpended debt proceeds held by trustee and reported as other operating revenue.

Other operating revenue (Note X)*	$400,000
Nonoperating revenue	
Unrestricted gifts and bequests	$400,000
Income on investments	
Board-designated funds	50,000
Assets whose use is limited under indenture agreement	100,000
Depreciation funds	150,000
Total nonoperating revenue	$700,000

*Note X to the financial statements would disclose that other operating revenue includes $75,000 of interest income on unexpended debt proceeds whose use is limited under an indenture agreement and which are held by a trustee.

Exhibit 4

Investment income on unexpended debt proceeds and interest expense reported as a net amount in operating expense.

Other operating revenue	$ 325,000
Operating expenses	
Salaries and professional fees	$ 9,800,000
Supplies and other expenses	7,300,000
Depreciation and amortization	600,000
Interest (Note X)*	400,000
Total operating expenses	$18,100,000
Nonoperating revenue (same as exhibit 3)	$ 700,000

*Note X to the financial statements would disclose that interest expense was net of $75,000 of interest income on unexpended debt proceeds whose use is limited under an indenture agreement and which are held by a trustee.

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APPENDIX G

Statement of Position 87-1

Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues

March 16, 1987

Issued by
Accounting Standards Division

American Institute of
Certified Public Accountants

AICPA

NOTE

This statement of position applies to all health care providers and provides guidance concerning medical malpractice insurance financial-reporting issues.

Statements of position of the Accounting Standards Division present the conclusions of at least a majority of the Accounting Standards Executive Committee, which is the senior technical body of the Institute authorized to speak for the Institute in areas of financial accounting and reporting. Statements of position do not establish standards enforceable under rule 203 of the AICPA Code of Professional Ethics. However, Statement on Auditing Standards (SAS) No. 5, *The Meaning of "Present Fairly in Conformity With Generally Accepted Accounting Principles" in the Independent Auditor's Report*, as amended by SAS No. 43, *Omnibus Statement on Auditing Standards*, identifies AICPA statements of position as another source of established accounting principles that the auditor should consider. Accordingly, members should be prepared to justify departures from the recommendations in this statement of position.

Table of Contents

Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues

Introduction

1. Health care providers have traditionally purchased occurrence-basis insurance to protect themselves against losses from malpractice claims. Such losses include the costs of claims investigation and settlement resulting from allegedly improper professional health care services provided to patients. The cost of such insurance is fixed at the beginning of the policy term, and the premium has been charged to expense pro rata over the term of the policy.

2. The changing social and economic environment has both increased the cost and limited the availability of occurrence-basis medical malpractice insurance. Insurance companies have substantially raised premiums or restricted the degree of risk they were willing to assume. As a result, some health care providers have dropped their insurance coverage; others have kept their coverage but modified it to retain more of their malpractice risk by accepting higher deductibles, by purchasing retrospectively rated policies, by forming captive insurance companies, or by joining with others to form multiprovider captive insurance companies. Still other providers have purchased claims-made policies, which cover only claims reported to the insurance carrier during the policy term. Today, few health care providers have full insurance protection against losses from medical malpractice claims, and careful evaluation of ongoing insurance protection is required whenever one of the above modifications is made.

3. Many health care providers established trust funds as a means of funding the cost of uninsured (also referred to as self-insured) malpractice claims and related expenses. Others simply pay such costs out of general funds when they are incurred.

4. Accounting for asserted and unasserted medical malpractice claims has become diverse. The diversity is compounded by the use

of captive insurance companies, retrospectively rated policies, claims-made insurance programs, and trust funds because accounting pronouncements offer no specific guidance in those areas. Neither the AICPA's 1972 *Hospital Audit Guide* nor the AICPA's 1978 Statement of Position (SOP), *Clarification of Accounting, Auditing and Reporting Practices Relating to Hospital Malpractice Loss Contingencies*, provides specific guidance on those accounting issues. Accordingly, this statement has been prepared (*a*) as a basis for reducing the existing diversity of practice and (*b*) as a guide on accounting for uninsured asserted and unasserted medical malpractice claims and related issues.

Definitions

5. The following are definitions of terms used in this statement.

Asserted claim. A claim made against a health care provider by or on behalf of a patient alleging improper professional service.

Claims-made policy. A policy that covers only malpractice claims covered by the policy reported to the insurance carrier during the policy term.

Discounting. Measuring the cost of malpractice claims at the present value of the estimated future payments.

Health care provider. A person or other entity or group of entities under common control that delivers health care services, including, but not limited to, hospitals, nursing homes, and practices of physicians, dentists, or other health care specialists.

Multiprovider captive. An insurance company owned by two or more health care providers that underwrites malpractice insurance for its owners.

Occurrence-basis policy. A policy that covers claims resulting from incidents that occur during the policy terms, regardless of when the claims are reported to the insurance carrier.

Reported incident. An occurrence identified by a health care provider, usually under some form of claim-management-reporting system, as one in which improper professional service may be alleged, thereby resulting in a malpractice claim.

Retrospectively rated policy. An insurance policy with a premium that is adjustable based on the experience of the insured health care provider or group of health care providers during the policy term.

Self-insurance. Risk of loss assumed by a health care provider. No external insurance coverage.

Tail coverage. Insurance designed to cover malpractice claims incurred before, but reported after, cancellation or expiration of a claims-made policy.

Trust fund. A fund established by a health care provider to pay malpractice claims and related expenses as they arise. (In the case of a government, the trust fund often is established as an "internal service fund.")

Ultimate cost. Total claim payments, including costs associated with litigating or settling claims.

Unasserted claim. A medical malpractice claim that has not been, but may in the future be, asserted by or on behalf of a patient related to a reported or unreported incident.

Unreported incident. An occurrence in which improper professional service may have been administered by the health care provider that may result in a malpractice claim. The occurrence, however, has not yet been identified by the health care provider under a formal or informal claims-reporting system.

Wholly owned captive. An insurance company subsidiary of a health care provider that provides malpractice insurance primarily to its parent.

Scope

6. This statement applies to all health care providers and their wholly owned and multiprovider-owned captive insurance companies.

Relevant Accounting Pronouncements

7. Three accounting pronouncements provide guidance on accounting for medical malpractice claims: FASB Statement No. 5, *Accounting for Contingencies*, FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss*, and the 1978 AICPA Statement of Position, *Clarification of Accounting, Auditing, and Reporting Practices Relating to Malpractice Loss Contingencies*. The following discussion cites relevant passages from those pronouncements.

Accounting for Uninsured Asserted and Unasserted Malpractice Claims

8. An issue in accounting for uninsured asserted and unasserted malpractice claims is whether a health care provider should accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims when incidents occur. Other accounting issues include how such losses should be accrued and how those accrued losses should be classified in the financial statements.

Discussion

9. Many health care providers that do not obtain insurance for their malpractice risks establish risk management systems to reduce their exposure to malpractice claims. Risk management systems are designed (*a*) to reduce the likelihood of incidents that may result in malpractice claims, (*b*) to identify such incidents that have occurred and to correct the underlying causes, (*c*) to minimize the amount of payments made on reported claims, and (*d*) to provide for the availability of financial resources to settle claims.

10. For accounting purposes, the two major categories of malpractice loss contingencies are asserted and unasserted claims. *Asserted claims* are claims made against a health care provider by or on behalf of a patient alleging improper professional service. *Unasserted claims* (that is, incurred but not reported claims) are claims that have not been asserted by or on behalf of a patient and may relate to either—

a. *Reported incidents*, which are occurrences that have been identified by the health care provider, usually under some form of claims management reporting system, as incidents in which improper care may be alleged, thereby resulting in malpractice claims, or—

b. *Unreported incidents*, which are occurrences that have not yet been identified by the health care provider under a formal or informal claims-reporting system as incidents in which improper professional service may be alleged, and can result in malpractice claims.

11. The 1978 SOP provides limited guidance on accounting for uninsured malpractice claims. That SOP requires estimated losses resulting from malpractice claims to be accounted for in accordance with FASB Statement No. 5 and FASB Interpretation No. 14.

Accordingly, an expense should be accrued if an incident has occurred that will probably result in an uninsured loss and if the amount can be reasonably estimated. In making the estimate, prior claim experience should be considered, including an analysis of the frequency of past claims. The SOP indicates that a qualified actuary may be helpful in deriving an estimate of claims incurred but not reported and also in quantifying the uncertainties inherent in such estimates.

12. FASB Interpretation No. 14 states that if it is probable a loss has been incurred but that only a range of loss can be reasonably estimated, the loss should still be accrued. However, in such circumstances, the most likely amount in the range should be accrued. If no amount is more likely than any other amount, the minimum amount should be accrued, and the amount of any potential additional loss should be disclosed in the notes to the financial statements.

Present Practices

13. Some health care providers accrue estimated losses from malpractice claims based on information developed from their risk management systems. Losses from asserted claims are based on the best estimate of the cost of settling or litigating the claims, including the expense of settlement and litigation (ultimate cost). Many of those estimates are made by claims managers or attorneys.

14. Losses from unasserted claims arising from reported incidents are estimated and accrued either individually or in groups. Individual accrual is based on an analysis of each incident; group accrual is based on the historical relationship between unasserted claims arising from reported incidents and eventual loss.

15. Some health care providers also estimate and accrue losses from unreported incidents. Those estimates are generally based on the provider's experience of the relationship between unreported incidents and eventual losses or on industry experience. Losses from reported and unreported incidents are often estimated with the help of actuaries.

16. Other health care providers accrue amounts for estimated losses from malpractice claims based on actuarially determined payments to a trust fund or captive insurance company. Many of those payments represent the present value of expected future payments for malpractice claims less amounts previously funded and

amounts to be funded in future years. Those amounts generally result in leveling the reported expense of malpractice claims over a period of years and are not usually based on incidents occurring in the current year.

Views on the Issues

17. Some believe that the ultimate costs of malpractice claims should be accrued when the incidents that cause them occurred, if it can be determined that it is probable that losses have been incurred and if the amounts can be reasonably estimated. However, they maintain that the ability to make reasonable estimates varies for asserted and unasserted claims. They believe that accrual of estimated losses from asserted claims and the related settlement and litigation expenses should be based on the best estimate of the costs of settling or litigating the claims.

18. These individuals also believe that estimated losses from reported incidents should be accrued if sufficient information is available from the health care provider's own experience to determine—either individually or on a group basis—that it is probable that losses have been incurred and that they can be reasonably estimated. In addition, they maintain that estimated losses from unreported incidents should also be accrued if the health care provider has sufficient statistics on its paid claims that resulted from unreported incidents to provide a basis on which to estimate the amount of such losses. However, if a health care provider does *not* have sufficient historical experience on which to estimate losses from reported or unreported incidents, they believe the cost of such claims should not be accrued. The existing contingency should be disclosed in the notes to the financial statements.

19. Others maintain that the actuarially determined payment to a trust fund or captive insurance company should be accrued as an expense in the health care provider's financial statements because the amount was determined by an actuary, who is a specialist in the field. They believe that Statement on Auditing Standards No. 11, *Using the Work of a Specialist*, supports their position. SAS No. 11 states in paragraph 9 that "if the auditor determines that the specialist's findings support the related representations in the financial statements, he may reasonably conclude that he has obtained sufficient evidential matter." Those who support accruing actuarially

determined payments contend that accountants do not have the level of expertise to challenge an actuary's recommendations.

20. Others believe that actuarially determined payments frequently include amounts that do not meet the criteria for accrual under FASB Statement No. 5 for the following reasons:

a. Actuarially determined payments generally result in leveling the cost of malpractice claims over a period of years. For example, if it is probable that a $1 million loss will occur some time in the next five years, $200,000 may be funded in each of the next five years. For accounting purposes, $1 million should be accrued in the year the incident occurred if the amount of loss can be reasonably estimated at that time.

b. Many actuarially determined payments are computed at the request of the health care provider at the beginning of a year or earlier, and, therefore, the health care provider's claim experience for that year is not considered.

c. The actuarial computations may be based on industry experience rather than on the health care provider's claim experience. If the health care provider's claim experience differs materially from the experience of others, the actuarial determinations would not conform with FASB Statement No. 5.

d. Actuarially determined payments may contain provisions for adverse deviation that do not conform with FASB Statement No. 5, which requires an accounting accrual based on reasonable estimates of incurred losses.

Conclusions

21. The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, should be accrued when the incidents occur that give rise to the claims, if it can be determined that it is probable that liabilities have been incurred and if the amounts of the losses can be reasonably estimated.

22. *Estimating the Amount of Loss.* If it is probable that a loss has been incurred and the information available indicates the loss is within a range of amounts, the most likely amount of loss in the range should be accrued. If no amount in the range is more likely than any other, the minimum amount in the range should be accrued, and the

potential additional loss should be disclosed if there is at least a reasonable possibility of loss in excess of the amount accrued. (See FASB Interpretation No. 14.) If the range of loss cannot be reasonably estimated, no loss should be accrued.

23. Estimated losses should be reviewed and changed if necessary at each reporting date; the amounts of the changes would be recognized currently as additional expense or reductions of expense.

24. *Asserted Claims and Unasserted Claims Arising From Reported Incidents.* Estimated losses from asserted claims should be accrued either individually or on a group basis, based on the best estimates of the ultimate costs of the claims. Estimated losses from unasserted claims arising from reported incidents should be accrued individually or on a group basis, using the relationship of past reported incidents to eventual claim payments. All relevant information, including industry experience, should be used in estimating the expected amount of asserted claims and unasserted claims arising from reported incidents.

25. *Unreported Incidents.* A health care provider should accrue estimated losses from unreported incidents based on its best estimate of the ultimate costs. Those estimates should be based on all available evidence that is relevant to estimating unreported incidents that have occurred as well as the *amount of loss* related to those estimated incidents. Such evidence may include industry experience, the provider's own historical experience, and the provider's existing asserted claims and reported incidents. The accrual should be limited to an estimate of the losses that will result from unreported incidents that are probable of having occurred before the end of the reporting period.

26. In estimating the extent to which unreported incidents are probable of having occurred, some health care providers may develop a range of possible estimates of the number of unreported incidents, including zero. However, the greater the volume of a health care provider's operations, the greater the likelihood that the provider's minimum estimate of the number of probable unreported incidents will be greater than zero.

27. *Use of Industry Experience.* In estimating losses from malpractice claims, a health care provider should use data on industry experience only to the extent that such data is relevant to developing an estimate specific to the entity. The relevance of industry data depends principally on the comparability of the health care provider with the entities whose experiences are used in developing that data. Various factors, such as the nature of operations, size, and geographic location, should be considered in assessing comparability. Further, industry data that is not current may not be relevant. How the health care provider plans to use the data affects which factors are more important in a given circumstance, as indicated in the following examples:

a. In estimating the amount of loss, the nature of the incident would typically be critical in using industry data.

b. In estimating the extent to which unreported incidents have occurred, the comparability of a provider's business activity and risk management system to that of the other providers included in the industry data would be critical in determining whether and how industry experience can be used. (Not being able to make such comparisons of the risk management systems would indicate that industry data should not be used in estimating the extent of a provider's probable unreported incidents.)

28. Accrued unpaid claims and expenses that are expected to be paid during the normal operating cycle (generally within one year of the date of the financial statements) should be classified as current liabilities; all other accrued unpaid claims and expenses should be classified as noncurrent liabilities.

29. *Disclosure.* A health care provider should disclose its program of medical malpractice insurance coverages and the basis for any related loss accruals. If the health care provider cannot estimate losses relating to a particular category of malpractice claims (for example, asserted claims, reported incidents, or unreported incidents) in accordance with paragraphs 22 through 27, the potential losses related to that category of claims should not be accrued. However, the contingency should be disclosed in the notes to the financial statements, as required by FASB Statement No. 5.

Disclosure of Discounting Accrued Unpaid Malpractice Claims

30. An issue in accounting for medical malpractice claims is what should be disclosed by health care providers that discount accrued unpaid medical malpractice claims.

Discussion

31. The relevant accounting pronouncements are not specific about whether unpaid malpractice claims should be recorded at the estimated ultimate cost of settlement or at the present value of anticipated future cash payments. Because of the substantial delay between the date an incident occurs and the date the claim is paid, the difference between recording the amount of accrued asserted and unasserted claims at their estimated ultimate cost of settlement and at their present value is significant.

Conclusions

32. A task force of the Accounting Standards Division is considering the accounting implications of certain discounting applications, including discounting insurance claims. Until the discounting issue is resolved, health care providers that discount accrued malpractice claims should disclose in the notes to their financial statements the carrying amount of accrued malpractice claims that are discounted in the financial statements and the interest rate(s) used to discount those claims (see FASB Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, paragraph 60(d)).

Accounting for Claims-Made Policies and Tail Coverage

33. An issue in accounting for a claims-made policy is whether a health care provider should accrue for the ultimate costs of malpractice claims and incidents not reported to the insurance carrier during the term of the policy. Other issues include (*a*) how that accrual should be made and (*b*) whether buying tail coverage satisfies the requirement to provide for the costs of malpractice claims and incidents not reported to the insurance carrier.

Discussion

34. Many health care providers now buy claims-made malpractice insurance. A claims-made policy differs from an occurrence-

basis policy in that it covers only claims reported to the insurance carrier during the policy term. If a claims-made policy is not continually renewed or if tail coverage is not obtained when the policy is discontinued, a health care provider is uninsured for malpractice claims reported to the insurance carrier after the termination of the policy, regardless of when the incidents occurred.

35. An accounting issue to be addressed is whether a health care provider with a claims-made policy should accrue a liability for estimated losses relating to unasserted claims and incidents not reported to the insurance carrier, although they may be covered by future claims-made policies.

36. A health care provider may terminate a claims-made policy and buy tail coverage. If so, another accounting issue to be addressed is whether the cost of tail coverage should be charged to expense when the decision is made to terminate the claims-made policy or whether the cost should be deferred and amortized to expense over the period that claims are expected to be reported.

Present Practices

37. Few health care providers now accrue for estimated losses from unasserted claims and incidents not reported to the insurance carrier that are expected to be covered under future claims-made policies.

38. Most health care providers charge the cost of tail coverage to expense in the periods in which they obtain the coverage.

Views on the Issues

39. Some believe that a claims-made policy represents a transfer of risk within the policy limits to the insurance carrier and that it is unnecessary to accrue for estimated losses from unasserted claims and unreported incidents to be covered under future claims-made policies. They maintain that such accrual would be necessary only if the health care provider decided not to renew a claims-made policy or the insurance carrier indicated it would not renew the policy and tail coverage was not going to be or could not be obtained.

40. Others believe that a claims-made policy does not transfer risk to the insurance carrier for unasserted claims and incidents not

reported to the insurance carrier; they maintain that the health care provider should accrue for such claims. The accrual should be reversed when the claims are subsequently reported and covered by a claims-made or tail coverage policy.

41. Some believe the premium for tail coverage should be charged to expense when the coverage is obtained because the premium relates to past occurrences.

42. Others believe recognition in expense of the cost of tail coverage should be deferred. They maintain that it should be charged to expense over the estimated period in which the claims will be reported because the tail coverage is a continuation of the claims-made policy.

Conclusions

43. A claims-made policy represents a transfer of risk within the policy limits to the insurance carrier for asserted claims and incidents reported to the insurance carrier; however, this policy does not represent a transfer of risk for claims and incidents not reported to the insurance carrier. Consequently, a health care provider that is insured under a claims-made policy should account for the estimated cost of those claims and incidents not reported to the insurance carrier in accordance with paragraphs 22 through 27. This should be done unless the health care provider has bought tail coverage and included the cost of the premium as expense in the financial statements for that period.

Accounting for Retrospectively Rated Premiums

44. The issues to be addressed in accounting for retrospectively rated premium policies are (*a*) how health care providers should account for premiums and (*b*) what disclosures of estimated losses should be made under such policies if the ultimate premiums are based primarily on each health care provider's loss experience or on the experience of a group of health care providers.

Discussion

45. The premium for a nonretrospectively rated policy is fixed for the period of the contract and is usually charged to expense pro rata over the contract period. However, for a retrospectively rated

policy, an estimated or deposit premium is generally paid to the insurance company at the inception of the contract period. The deposit premium usually consists of a minimum premium, representing the insurance company's expenses and profits, plus an amount for estimated claims experience. During the term of the policy, the deposit premium is adjusted, subject to any minimum and maximum premium limitations of the contract, based on the experience of the health care provider.

46. Some retrospectively rated policies are primarily based on the experience of the individual health care provider and some are primarily based on the experience of a group of health care providers. Other policies may be based on some combination of both individual and group experience.

Present Practices

47. Some health care providers account for minimum premiums paid to insurance companies on retrospectively rated policies as expense over the period of coverage and recognize estimated losses in excess of the minimum premium from asserted and unasserted claims as additional insurance expense for the period.

48. Others amortize premiums on retrospectively rated policies over the period of coverage and recognize adjustments resulting from favorable or unfavorable claim experience in the financial statements when the insurance company reports them.

Views on the Issues

49. A retrospectively rated policy may provide that the insurer will not return the minimum premium regardless of the degree of favorable experience and, if experience is unfavorable, that the insured will only be required to pay a maximum amount. Some believe an estimate of the total premium ultimately to be paid should be charged to expense over the term of the contract.

50. Those who support that view maintain that health care providers retain risk of loss up to the maximum premium under those contracts. Estimated losses from asserted and unasserted claims should be accrued as indicated in paragraphs 22 through 27 up to that maximum amount.

51. Others believe that minimum premiums on retrospectively rated policies should be amortized pro rata over the period of coverage. Retrospective premium adjustments should be recorded as adjustments of insurance expense when the insured is notified of such adjustments. Those who support this view maintain that the premium is the best estimate of losses from asserted and unasserted claims and, therefore, should be the insurance expense for the period.

Conclusions

52. A health care provider with a retrospectively rated medical malpractice insurance policy whose ultimate premium is based primarily on the health care provider's loss experience should account for the minimum premium as expense over the period of coverage under the policy and accrue estimated losses from asserted and unasserted claims in excess of the minimum premium as indicated in paragraphs 22 through 27. However, such estimated losses should not be accrued in excess of a stipulated maximum premium. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in paragraphs 22 through 27, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

53. A health care provider insured under a retrospectively rated policy with premiums based primarily on the experience of a group of health care providers should amortize the initial premium to expense pro rata over the policy term. The provider should also accrue additional premiums or refunds on the basis of the group's experience to date, which should include provision for the ultimate cost of asserted and unasserted claims before the financial statement date, whether reported or unreported. The health care provider should disclose (*a*) that it is insured under a retrospectively rated policy and (*b*) that premiums are accrued based on the ultimate cost of the experience to date of a group of providers. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in paragraphs 22 through 27, it should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

Accounting for Medical Malpractice Claims Insured With Captive Insurance Companies

54. In accounting for medical malpractice claims insured with wholly owned and multiprovider owned captive insurance companies, an accounting issue to be considered is how health care providers should account for estimated losses from asserted and unasserted claims.

Discussion

55. Some health care providers have formed wholly owned subsidiaries to insure the parent entity and possibly other health care providers. Those entities are captive insurance companies for which FASB Statement No. 60 specifies the accounting.

56. Other health care providers have formed multiprovider captive insurance companies to insure their medical malpractice claims. Those entities are also captive insurance companies for which FASB Statement No. 60 specifies the accounting. A multiprovider captive insurance company is commonly formed by a group of health care providers that are related geographically, that are affiliated or under common control, such as by members of a religious community, or that have similar malpractice claims experience. A multiprovider captive insurance company may be formed to (*a*) spread the risk of malpractice claims among a number of similar institutions, (*b*) obtain excess coverage at a lower cost, or (*c*) provide for advance funding of the cost of malpractice claims within the provisions of reimbursement regulations. The captive may retain the entire risk assumed from its insureds or it may obtain excess coverage from a commercial insurance company.

57. Premiums on some policies issued by multiprovider captives are fixed for the period of the contract. However, premiums on many policies issued by such insurers are retrospectively rated. Such premiums may be based on the experience of the individual health care provider or on the experience of the group. The arrangements between providers and their captive may be complex; a careful analysis is generally required to determine the extent of coverage that in fact is provided by the captive. If, for instance, the insurance contract requires a premium essentially equal to claims incurred by the provider plus a fee for expenses and profit, the captive is, in effect, only a claims-paying agent.

Present Practices

58. Financial statements of health care providers generally do not disclose the method of accounting for captive insurance companies.

Views on the Issues

59. Some believe that a health care provider that is insured by its wholly owned captive is, in substance, uninsured. They believe, therefore, that the same considerations apply in accounting for estimated losses from uninsured asserted and unasserted malpractice claims of the parent as described in paragraphs 21 through 29. FASB Statement No. 5, paragraph 27, states that "uninsured risks may arise in a number of ways, including . . . insurance through a subsidiary or investee to the extent not reinsured with an independent insurer." A footnote to that paragraph states that "the effects of transactions between a parent or investor and a subsidiary or investee insurance company shall be eliminated from an enterprise's financial statements."

60. Similarly, some believe that policies issued by multiprovider captives in which the premiums are based on the experience of the individual health care providers are, in substance, not insurance. Thus, the premiums should be accounted for as expense over the periods of coverage; estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 21 through 29. However, if the premiums are based on the experience of the group, they should be amortized to expense pro rata over the terms of the policies.

61. Others believe that for retrospectively rated policies issued by multiprovider captives, with the premiums based only on the health care provider's individual experience, the initial premiums should be amortized to expense pro rata over the terms of the policies. Premium adjustments should be recorded only when the health care providers are notified by the multiprovider captives.

Conclusions

62. The financial statements of a health care provider insuring medical malpractice claims through a wholly owned captive insurance subsidiary must include provision for estimated losses from asserted and unasserted claims as indicated in paragraphs 21 through

29. That may be done directly in the financial statements of the health care provider or in consolidation of the financial statements of the wholly owned captive.

63. A health care provider insured by a multiprovider captive insurance company for medical malpractice claims under a retrospectively rated insurance policy whose ultimate premium is primarily based on the health care provider's experience up to a maximum premium, if any, should account for such insurance as indicated in paragraph 52.

64. A health care provider insured by a multiprovider captive insurance company for medical malpractice claims under a retrospectively rated policy based primarily on the experience of a group of health care providers should account for such insurance as indicated in paragraph 53. However, the health care provider should consider whether the economic substance of the multiprovider captive is sufficient to relieve the health care provider from further liability. The health care provider should disclose (*a*) that it is insured under a retrospectively rated policy of a multiprovider captive and (*b*) that premiums are accrued based on the captive's experience to date.

65. A health care provider that is insured by a multiprovider captive should disclose in its financial statements that it is insured by a multiprovider captive, and it should disclose its ownership percentage in the captive as well as the method of accounting for its investment in and the operations of the captive. In addition, if the health care provider cannot make the necessary estimates of losses from asserted or unasserted claims as indicated in paragraphs 22 through 27, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

Accounting for Trust Funds

66. Another issue is how a health care provider should account for a trust fund established to make resources available to settle malpractice claims.

Discussion

67. One of the objectives of a risk management system is to make sure that sufficient resources are available to settle malpractice claims as they come due. Some health care providers establish trust funds in an attempt to make sure that financial resources are available to pay claims. In most circumstances, a trustee controls the trust fund assets and the trust agreement provides that the assets can be used only to investigate, litigate, and settle malpractice claims and to pay administrative expenses of the trust fund.

68. Diverse practices have developed for reporting medical malpractice trust funds and their revenues and administrative expenses in the financial statements of the health care provider.

Present Practices

69. Some health care providers treat a payment to a trust fund as a transfer of funds from one case account to another. Others exclude the trust fund from their financial statements and charge the payment to an expense account. They recognize a liability for unpaid claims only to the extent that claims exceed the amount in the trust fund. Revenues, generally interest income, and administrative expenses of the trust fund are recorded in the financial statements of the health care provider only if the trust fund is included in the statements.

Views on the Issues

70. Some believe that a trust fund, whether legally revocable or irrevocable, should be included in the health care provider's financial statements because establishing a trust fund does not relieve the health care provider of the financial responsibility for malpractice claims. A health care provider cannot limit its legal obligation for malpractice claims to the amount in the trust fund; a malpractice claimant can look to all the assets of the health care provider as well as to the trust fund to satisfy a malpractice claim. A medical malpractice trust fund cannot be compared to a pension fund because, under certain circumstances, a company's pension obligations can be limited to the amount in the pension fund.

71. Others maintain that a medical malpractice trust fund is comparable to a pension fund and should not be reported in the health care provider's financial statements. They believe that because

future malpractice claims will be paid from the trust fund, establishing a fund provides a transfer of risk and that only malpractice claims exceeding the amount in the trust fund should be reported in the health care provider's financial statements. They also maintain that there is no significant distinction for accounting purposes between assets held in revocable and irrevocable trusts because the assets of the trust are used solely to discharge obligations for unpaid claims.

72. Some believe that a trust fund included in the financial statements of the health care provider should be classified as a current asset, and others maintain that it should be classified as a noncurrent asset. Still others believe that classification should depend on the classification of estimated unpaid malpractice claims.

Conclusions

73. A trust fund, whether legally revocable or irrevocable, should be included in the financial statements of the health care provider. A portion of the fund equal to the amount of assets expected to be liquidated to pay malpractice claims classified as current liabilities should be classified as a current asset; the balance of the fund, if any, should be classified as a noncurrent asset. In the financial statements of the health care provider, revenues of the trust fund should be included with other operating revenues; the administrative expenses of the trust fund should be included with other administrative expenses. In some circumstances the foregoing may not be possible: for example, if a common trust fund exists for a group of health care providers; if the health care provider is part of a common municipality trust fund; and if legal, regulatory, or indenture restrictions prevent the inclusion of a trust fund in a health care provider's financial statements. In those circumstances, the provisions of paragraphs 74 and 75 still apply.

74. Estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 21 through 29 and should not be based on payments to the trust fund.

75. A health care provider's financial statements should disclose the existence of the trust fund, and, if the trust is irrevocable, that should also be disclosed.

Effective Date and Transition

76. This statement is effective for fiscal years beginning after June 30, 1987, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively. In the year this statement is first applied, the financial statements should disclose the nature of any restatement and its effect on income before extraordinary items, net income, and related amounts per share for each year restated.

77. If retroactive restatement of all years presented is not practicable, the financial statements presented should be restated for as many consecutive years as practicable. The cumulative effect of applying the statement should be included in determining net income of the earliest year restated, which is not necessarily the earliest year presented. If it is not practicable to restate any prior year, the cumulative effect should be included in net income in the year in which the statement is first applied, in conformity with paragraph 20 of APB Opinion 20, *Accounting Changes*. For that year, what should be disclosed is the following: the effect on income before extraordinary items, net income, and related per share amounts of applying this statement in a year in which the cumulative effect is included in determining that year's net income.

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